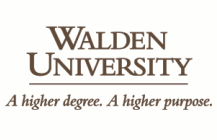

2017

Effect of Intimate Partner Violence on Children of Puerto Rican Women

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This is to certify that the doctoral dissertation by

Maria Natal-Gopin

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2017

Abstract

Effect of Intimate Partner Violence on Children of Puerto Rican Women

by

Maria Natal-Gopin

MSN, Walden University, 2009

BSN, Hunter College, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

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November 2017

Abstract

Intimate partner violence [IPV] is a preventable and costly societal issue that has reached epidemic proportions. Women are often the victims of IPV, and millions of children are exposed to it annually. The purpose of this study was to explore experiences of Puerto Rican mothers and their perceptions of how IPV exposure may have impacted their children using resilience theory. Data were collected via audiotaped individual interviews with 9 Puerto Rican mothers who endured an array of escalating IPV, often exacerbated by the perpetrators use of alcohol or drugs, and had IPV-exposed children aged 6 -11 years. Data analysis integrated content and thematic procedures. Interview data was transcribed, read, audited and coded based on compelling statements, quotes, and sentences made by the participants. The coded clusters were further evaluated, reduced to significant statements, then grouped into themes that captured the essence of the participants lived experiences and of the group. The mothers separated because they feared for their lives and the effect of IPV on the children. Once separated the mothers felt isolated, lived in shelters which were unconducive to childrearing, and had challenges navigating the system. They perceived their IPV-exposed children exhibited a multitude of behaviors including PTSD but that most were showing signs of resilience. Their IPV was perpetrated by males who were mostly the biological fathers of their children who used controlling behaviors towards the kids. The potential positive social change impact of this study is to empower Puerto Rican mothers to disclose IPV and to better inform health care providers regarding the impact of IPV on children aged 6 -11 years in an effort to increase the health, well-being, and resiliency of this vulnerable population.

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Dedication

This study is dedicated to my mother, Maria Alvarez Natal, who passed away in 2000. She was a dedicated mother and best friend who provided me with some powerful lessons on the importance of independence and education. Her love, strength and guidance empowered me to engage in this journey of becoming an expert in my field. Throughout this journey I felt her presence as a guardian angel who also helped clear paths when I encontered obstacles. I also dedicate this study to my husband, Richard Gopin, who always believed in me and encouraged me even when I doubted myself and, to my son, Gabriel Gopin, for understanding that this journey was always meant to be a lesson that learning is a lifelong process.

I also dedicate this study to the community partners who so willingly opened up their doors and posted my study fliers and to the brave and courageous women who took the time to meet with me in hopes of helping others who have had similar experiences.

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I would also like to thank Dr. Schwab and Dr. Feldman for your support, feedback and for acccompanying me throughout this amazing journey.

Lastly, to my friends and family members, thank you for your flexibility, help with chores, and for understanding when I couldn't attend events because of school commitments. Thank you for your words of encouragement and for always believing in me.

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Chapter 1: Introduction to the Study

Introduction

Intimate partner violence [IPV] is a multilevel issue that affects the family, community, and society. Researchers have found that women are more likely to be victims of nonfatal violent IPV, to experience injuries during violent assaults, and to be murdered by an intimate partner than men (Bureau of Justice Statistics [BJS], 2012; Catalano, Smith, Snyder, & Rand, 2009; Centers for Disease Control & Prevention [CDC], 2010). The healthcare costs incurred from IPV related injuries, and fatalities are overwhelming (CDC, 2003). Fifteen years ago, the CDC (2003) estimated that the direct medical and mental health care services cost of nonfatal IPV exceeded $4 billion dollars per year. An additional $0.9 billion dollars was incurred from losses of productivity, and another $0.9 billion dollars from loss of earnings occurred as a result of femicide. The CDC (2003) total estimated costs of $5.8 billion dollars were not representative of the actual expenditures arising from IPV due to lack of data and underreporting (BJS, 2012; World Health Organization [WHO], 2001).

In contrast, Max, Rice, Finkelstein, Bardwell, and Leadbetter (2004) and Pearl (2013) posited that the direct and indirect costs of IPV exceeds $8.3 billion dollars annually. However, these expenses do not take into account the costs associated with children who are exposed to IPV which have yet to be determined (Schutz et al., 2013). They also don't take into account the social costs of unreporting (Carrell & Hoekstra, 2014), the costs associated with legal, social and supportive services including housing as well as foster care, financial assistance, or the costs of human suffering including fear and

pain (CDC, 2003). PricewaterhouseCoopers [PwC] Australia (2015) estimated that in 2014 IPV costs in Australia were $12.6 billion annually including pain, suffering and untimely mortality but the costs would likely be greater in the United States because of the differences in the size of the population. PwC (2015) forecasted that over the next five years IPV costs could exceed $16 billion dollars.

Women of childbearing age are at greatest risk for IPV (U. S. Preventive Services Task Force [USPSTF], 2013) and when they are mothers, their children become the innocent victims of child IPV exposure. Catalano et al. (2009) estimated that almost 40% of households with female victims of IPV have children younger than 12 years of age living in the home. While the National Crime Victimization Survey [NCVS] data provides valuable information regarding children younger than 12 years of age who may have been exposed to IPV, it underestimates the magnitude of the problem because it omits children over 12 years old, and homeless as well as shelter-based families with kids who are at increased risks for IPV exposure.

Child exposure to IPV can occur in a variety of ways (Holden, 2003) but the majority of children become exposed to it by seeing it, listening to it, or hearing of the incident (Hamby, Finkelhor, Turner, & Ormrod, 2011). The National Survey of Children's Exposure to Violence [NatSCEV] focused on children's exposure to violence across all ages (ages 0–5, 6–9, 10–13, and 14–17 years), settings, and timeframes (Crimes Against Children Research Center, n.d.). According to data derived from the NatSCEV I survey conducted in 2008 on child IPV exposure, approximately 1 in 15 youth, or 6.6%, had been exposed to some form of physical assault between their parents in the year

(Hamby et al., 2011). A roughly equivalent percentage, 5.7%, were exposed to psychological/ emotional IPV (verbal threats, punching walls, and throwing, breaking, or destroying household items) in the past year, and displaced aggression, including seeing a parent break something, hit a wall, or throw things, was reported most often (4.9%) (Hamby et al., 2011). Also, 14-17-year-olds had the highest rates of lifetime exposure to IPV followed by 6-9 year-olds and then 0-5 year-olds (Hamby et al., 2011).

The NatSCEV 11 was a follow up survey conducted in 2011 and was a replicate of NatSCEV I with a different population and additional questions which would require critical actions (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015). Researchers indicated that 6.1% of the sample had witnessed IPV in a one-year timeframe and 17.3% had been exposed to IPV throughout their lifetimes which increased with age. As in NatSCEV I, NatSCEV II found an increased likelihood of multiple types of exposures to violence and polyvictimization (Finkelhor et al., 2015; Hamby et al., 2011). The percentages and trends from NatSCEV 1 and 11 for exposure to violence including witnessing IPV, child neglect and maltreatment, and indirect victimization declined in the past year but the changes in the trends weren't significant (Finkelhor et al., 2015). However, NatSCEV may also underestimate true IPV exposure rates among children because it requires (a) parental consent, (b) data collection on children younger than nine years of age is based on information provided by the parents or caregivers, (c) only one child per household is interviewed, and (d) it is based on recall (Hamby et al., 2011). Additionally, cooperation rates for data collection among minority and low-income

groups, including Hispanics, was less than 45% for NatSCEV I (Hamby et al., 2011) which further supports the need for my study.

The effects on children exposed to IPV can be immediate, ongoing throughout their childhood, and can carry over into their adulthood (Felitti et al., 1998; Futures Without Violence, n.d.; Graham-Bermann & Perkins, 2010). They can be direct, as a result of having been exposed to the IPV, or indirect due to impaired parental relationships as a consequence of the stress associated with IPV. Dose-response effects are noted in IPV-exposed children, and not all children experience or depict symptoms of trauma (Schutz et al., 2013). Rather than focus on the deleterious effects that IPV exposure has on children, I explored resilience or the ability to adapt to exposure to adverse events among primary school-age Puerto Rican children, from the perspective of their mothers.

This study was conducted because the literature on child exposure to IPV among Puerto Rican children is limited (Mogro-Wilson, Negroni, & Hesselbrock, 2013). Puerto Ricans are the second largest group of Hispanic origin in the United States (U. S. Census Bureau, 2010) and IPV and subsequent child exposure to it is a costly and preventable public health issue. In addition, a cultural mindset is essential to working with individuals, families, and communities to eliminate gender discrimination, stereotypes and child exposure to IPV and this has been lacking in previous studies (Mogro-Wilson, 2013; Nahavandi, 2012; Wilson & Neville, 2009).

The potential long term social implications of this study include empowering mothers to change their help-seeking behaviors by disclosing IPV (Morse, Lafleur,

Fogarty, Mittal, & Cerulli, 2012), influencing culturally sensitive IPV screening and referral practices among health care professionals (Sprague et al., 2012; Taft et al., 2013), and providing children with an opportunity to become productive citizens as a result of early interventions (Greeson et al., 2014; Morse et al., 2012; Sprague et al., 2012; Taft et al., 2013). The following sections of this chapter include background information of the phenomenon, a problem statement, the purpose of the study, the research questions, the theoretical framework for this study, the nature of the study, assumptions, scope and delimitations, limitations, significance, and a summary.

Background

Child exposure to IPV places some children at greater risk for growth and developmental problems before their born and throughout their childhood (Felitti et al., 1998; Gluckman, Hanson & Mitchell, 2010). Such challenges can influence their stress responses, coping mechanisms, and overall adjustment (Bell, Goodman, & Dutton, 2009; Masten, 1994, 2014; McCaw, Golding, Farley, & Minkoff, 2007; Yates, Dodds, Sroufe, & Egeland, 2003). The distress that IPV-exposed children experience may be externalized in behavioral problems such as anxiety, aggression or hyperactivity, or internalized in withdrawn and fearful behaviors. Internalizing and externalizing behaviors have been linked to mental health, chronic diseases and cancer later in life (Brown, Thacker, & Cohen, 2013; Felitti et al., 1998). Additionally, some IPV-exposed children have a higher predisposition to becoming victims or perpetrators themselves (Hamby et al., 2011; Moroz, 2005). Lastly, IPV-exposed children are also at greater risk for neglect

and abuse as a result of impaired parenting capabilities (Goddard & Bedi, 2010; Hartley, 2004).

However, some IPV-exposed children do not manifest any symptoms of internalization or externalization (Analytic Sciences, Inc., 2002; Graham-Bermann, Gruber, Howell, & Girz, 2009). The reason for this appears to be a combination of individual, parental, family, community, and social factors that act as protective mechanisms which mediate the risks resulting from IPV exposure in children (Masten, 1994, 2014). The process of resiliency in children has been associated with the use of developmentally appropriate family interactions which provide a balance that shapes their regulatory capacity (Howell, Graham-Bermann, Czyz, & Lilly, 2010; Masten, 2014). In such cases, resilience develops as a result of successful recovery from exposure to adverse experiences (Obradovíc, 2012). Protective factors such as the child's age, level of intelligence, attachment, nurturing familial relationships, parental monitoring and involvement, sibling's, role models, and social resources may all promote the competence and adaptive capacity of children thereby ultimately influencing resiliency (Howell et al., 2010; Masten, 2014; Newland, 2014).

Additionally, culture affects the developmental adaptive capacity of children (Aymer, 2008; Masten, 2014; Mogro-Wilson, 2013), and this is important for Hispanic Americans, among whom there are several distinct cultural sub-groups. Most of the literature categorizes Hispanics or Latinos into one category (Humes, Jones, & Ramirez, 2011), but there is a need to explore how the unique subcultural values and beliefs influence Hispanic sub-groups. This study is needed because exploring resiliency from a

cultural perspective is vital to developing effective culturally sensitive primary, secondary and tertiary prevention strategies. Furthermore, it is essential to decreasing preconceived biases.

Previous studies on the experiences of Puerto Rican mothers who have IPV-exposed children are limited (Mogro-Wilson et al., 2013) and did not address the unique conflicts, barriers and challenges faced by this group. For example, in their cross-sectional study, Mogro-Wilson et al. (2013) explored how acculturation, parenting, and IPV may predict child behavioral problems among the Puerto Rican parent-child dyad participants where one parent had a documented substance abuse disorder. This study did not focus on the experiences of Puerto Rican mothers in terms of the group's unique risks and protective factors which I addressed in my study. Additionally, Mogro-Wilson et al. (2013) did not address the frequency or severity of IPV or the context of the child's IPV exposure which are factors that may influence resiliency which I will explore from the perspective of the mothers. Thus, examining the experiences of Puerto Rican mother's will aid in informing an identified gap related to their perceptions of how IPV exposure may have impacted their children aged 6-11 years.

There is a need to provide culturally tailored programs which focus on resiliency and are based on the expectations of the population, and accounts of such programs are lacking in the literature for Puerto Ricans (Masten, 2014; Mogro-Wilson, 2013). The alignment of education and intervention programs with Puerto Rican values and beliefs could aid in addressing the unique cultural conflicts, barriers and challenges they may encounter (Amanor-Boadu, Messing, Stith, Anderson, & Sullivan, 2012; Aymer, 2008;

Fine, Roberts, & Weis, 2006; Milan & Wortel, 2015), and supporting families and children exposed to IPV in developing resiliency over time (Masten, 2007, 2014).

Problem Statement

The WHO (2002) and Breiding, Basile, Smith, Black, and Mahendra (2015) describe IPV as stalking, coercive tactics, physical, sexual, emotional, or economic abuse, or its threat, from one partner in a relationship to another. Family violence has affected millions of households for many years, but the effects of childhood exposure to IPV have only recently come to the forefront (United Nations Children's Emergency Fund [UNICEF], 2006). In the United States, millions of children are repeatedly exposed to IPV (Hamby et al., 2011; McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Child exposure can occur in many ways (Holden, 2003) but up to 90% of children directly witness physical violence (Hamby et al., 2011). A number of researchers have found that the children of battered women tend to internalize or externalize the dysfunctional behaviors to which they are exposed, and experience higher rates of abuse and neglect as they grow older (Bell et. al., 2009; McCaw et al, 2007; Yates et al., 2003). IPV exposure in childhood can also lead to a range of short and long-term behavioral, physical, social, and environmental challenges throughout their life (Felitti et al., 1998; Middlebrooks & Audage, 2008). Disclosure of past violence is an important part of healing (Liebschutz, Battaglia, Finley, & Averbuch, 2008) but personal, situational, social, and cultural factors influence disclosure (Heise, 1998). Cross-cultural and other between-group differences can affect attitudes towards IPV, adherence to cultural ideals,

how IPV is perceived, child-parent relationships, and help-seeking behaviors (Beauchamp, Lindsay, Hunter, & Talavera, 2012; Dietrich & Schuett, 2013).

In a 10-year timeframe between 2000 to 2010, the U.S. Hispanic population has grown by almost 45%, as the largest minority group, the Hispanic population is forecasted to comprise nearly 30% of the total population by 2060 (Colby & Ortman, 2015; Humes et al., 2011). The terms Latino or Hispanic are used interchangeably to account for a variety of ethnicities including Cuban, Mexican, Puerto Rican, and other cultures that are grouped into a multitude of races (Humes et al., 2011). Among Hispanic subgroups, some researchers report that Puerto Rican's have the highest prevalence of IPV in the United States (Bassuk, Dawson, & Huntington, 2006; Kaufmann, Jasinski, & Aldarondo, 1994; Roure, 2011). Identified risk factors associated with IPV include being female, having young children, unemployment, and having a low socioeconomic status (CDC, 2015a). Puerto Rican's, the second largest group of Hispanic origin in the US, are less likely to be married, are more apt to live in poverty, and have higher rates of teenage pregnancies than other Hispanic subgroups (Brown & Patten, 2016; U. S. Census Bureau, 2010). In the United States, approximately 40% of all Puerto Rican family households have children younger than 17 years of age, and most of these children (24%) are 9 years old or younger (Collazo, Ryan, & Bauman, 2010).

The role of culture on IPV and children's resilience to it, has been explored by several author's (Edelson, Hokoda & Ramos-Lira, 2007; Grahamm-Bermann et al., 2009; White & Satyen, 2015; Yoshioka & Choi, 2005). However, research on how Hispanic cultural norms, values, beliefs, and attitudes may influence IPV-exposed children is

sparse (Mogro-Wilson et al., 2013). The South Bronx community, where the New York City Department of Health and Mental Hygiene [DOHMH] (2008) study took place, had been deemed high risk for IPV as a result of a combination of these risk factors (Fernandez-Lanier & Gilmer, 2008). Examining this issue was vital to increasing disclosure, decreasing IPV risks and to improving the resiliency of IPV-exposed children using culture-centered approaches (American Psychological Association [APA], 2003; Morse et al., 2012). The positive social change aspects of this study included empowering mothers to change their help-seeking behaviors by disclosing IPV (Morse et al., 2012), influencing culturally sensitive IPV screening and referral practices among health care professionals (Sprague et al., 2012; Taft et al., 2013), and ultimately providing children with an opportunity to become productive citizens as a result of early interventions (Greeson et al., 2014Morse et al., 2012; Sprague et al., 2012; Taft et al., 2013). The gap I identified in the literature related to the lack of research regarding the perceptions of Puerto Rican mothers who have IPV-exposed children on the affects that exposure had on their children, and the need to explore how the unique Puerto Rican values, attitudes, and beliefs influenced risks and protective factors in their IPV-exposed children (Fine et al., 2006; Mogro-Wilson et al., 2013). In this study, the mothers will be interviewed because the majority of IPV victims are women of child-bearing age (Black et al., 2011; USPSTF, 2013; WHO, 2013) and up to 88% of IPV incidents that children are exposed to are perpetrated by males including fathers or boyfriends (Hamby et al., 2011).

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of Puerto Rican mothers who are victims of IPV, and their perceptions of how IPV may have influenced their children aged 6-11 years, in order to aid in the development of supportive culturally appropriate interventions.

Research Questions

The research questions for the study are:

Research Question 1: What are the lived experiences of Puerto Rican mothers who are victims of IPV?

Research Question 2: What are the perceptions of Puerto Rican mothers who are victims of IPV on how exposure to IPV has influenced their children aged 6-11 years?

Theoretical Framework for the Study

The theoretical framework for this study was Masten's (1994) resilience theory, which provided a socio-ecological context for child care and protection (Barron, Miller & Kelly, 2015; Garmezy, Masten & Tellegen, 1984; Masten, 1994) and for examining the multilevel issues associated with child exposure to IPV (CDC, 2015b; Masten, Best, & Garmezy, 1990; WHO, 2010). This theory focuses on the developmental processes which are inherent human capabilities that lead to resiliency and how they can best be protected. It posits that resilience is a nonlinear process whereby risks can be directly or indirectly mediated by protective factors across various levels (Masten, 1994, 2014).

The central concepts of the phenomenon of resilience for my study were based on the psychosocial developmental stages of children aged 6 -11 years (Erikson, 1993).

Positive social interactions play a key role in the child's ability to develop confidence (Erikson, 1993) which is an adaptive system that promotes resilience (Masten, 2001, 2014). The central concepts of resilience for the IPV-exposed child, aged 6 -11 years, were defined with regards to protective processes which enhanced adaptation (Masten, 1994, 2014). Such protective factors can be viewed in terms of internal assets and external resources (Masten, 2007) at the individual, interpersonal and community levels (CDC, 2015b).

Internal Assets

For this study, the term internal assets included the capacity for self-regulation, coping, hope and social competence. Self-regulation was defined as the child's ability to cope with stress and confidently complete tasks based on their developmental stage (Gillespie, Chaboyer, & Wallis, 2007; Khanlou & Wray, 2014; Masten, 2007). Coping related to the child's abilities to use adaptive problem-focused strategies to appraise external or internal stressors (Gillespie et al., 2007; Masten, 2001). Hope was the child's belief's that goals could be accomplished (Gillespie et al., 2007; Masten, 2007). Lastly, social competence referred to the child's capacity to engage in prosocial relationships with positive networks of friends and family members (Masten, 2001, 2007).

External Resources

External multilevel systems play a role in the development of resilience **(**Gewirtz & Edleson, 2007; Masten, 2007). One external resource is a supportive quality relationship which is based on a secure attachment, parental involvement, and communication (Khanlou & Wray, 2014; Masten, 2001, 2007). Another external resource

is an adult role model outside of the immediate family who is supportive and encouraging (Khanlou & Wray, 2014; Masten, 2007, 2014). Lastly, the social environment may be an external resource if it includes community access to and involvement in youth organizations or other extracurricular activities (Khanlou & Wray, 2014) and living in a close-knit community (Gewirtz & Edleson, 2007; Masten, 2007).

In my literature review, I found only a few studies which applied resilience theory to the topic of child-exposure to IPV and none of them addressed Puerto Ricans. Resilience theory has been applied in the past by Howell et al. (2010) to assess the individual prosocial skills and emotional regulation of preschool children who had been exposed to varying degrees of IPV in a sample of primarily African-American women and children who resided in the community (45%) or a shelter (55%). The severity of violence experienced by the mothers had a direct effect on the children's resilience, but unexplored extrinsic factors may have accounted for some of the variability in the research outcomes (Howell et al., 2010).

In a quantitative study, Graham-Bermann et al. (2009) utilized resilience theory to explore family and child factors which may have played a role in the resiliency of children exposed to IPV. They found that having been exposed to less severe forms of IPV and their relationships with a stable mother with intact parenting skills had a positive influence on child resiliency (Graham-Bermann et al., 2009). The geographic area of the study was in Michigan and the participants were primarily Caucasian (52%) which limited its generalizability and transferability (Creswell, 2013). In addition to the few studies on child IPV exposure which utilized resilience theory, the theory has been

widely applied to the topic of child abuse and neglect (Herrenkohl, Tajima, Whitney, & Huang, 2005; Toth, Cicchetti, & Kim, 2002).

I used resilience theory as a preliminary theoretical framework to examine risk and protective factors including internal assets and resources which may have impacted the IPV-exposed child's coping mechanisms in the face of exposure to traumatic events (Fergus & Zimmerman, 2005; Masten, 1994; Rutter, 1985; Western Australian Centre for Health Promotion Research, 2010). I also used the theoretical framework to guide the research process, to focus the study's design (Creswell, 2013) and to spotlight concepts as well as potential relationships (Maxwell, 2005).

Dahlberg and Krug (2002) and the WHO (n.d.) recommended an ecological perspective to exploring individual, cultural and community factors which may influence IPV, the resiliency of victims and their families, can promote changes in social norms, and potentially decrease child IPV exposure. Exploring these issues from the perspective of the mothers, using a qualitative transcendental phenomenological approach, adds the perspectives of the participants lived experiences in relation to their child's exposure to IPV (Creswell, 2013; Moustakas, 1994). Furthermore, resilience theory related to the research questions because the questions sought to describe the meaning of the phenomenon regarding the effects that exposure to IPV had on the child based on the participant's perceptions. In Chapter 2 resilience theory is explained in more detail.

Nature of the Study

In this study I focused on the subjective perceptions of Puerto Rican mothers, with children aged 6-11 years on how exposure to IPV had affected their children.

Through the use of a phenomenological approach I explored the *"what"* and *"how"* of the phenomenon by gathering rich-thick descriptions that captured the essence of these mothers' experiences as recommended by Creswell (2013), Miles, Huberman and Saldaña (2014), and Moustakas (1994). I sought to understand IPV and how it may have impacted children aged six-11 years who were exposed to it as perceived by their Puerto Rican mothers.

To achieve my goal, I interviewed Puerto Rican mothers, aged 18 years and older, who had children, aged 6-11 years, who had been exposed to IPV. Each mother was asked to participate in two audio-taped, one-on-one, semi-structured interviews using a content validated and piloted interview protocol in English (Appendix A) or Spanish (Appendix B) based on the participant's preferences. Data collection also included the researcher's observational and reflective notes. The raw data were transcribed into NVivo. Data analysis integrated constant comparison procedures during data collection (Creswell, 2013; Miles et al., 2014; Patton, 2015), reading, transcribing, and organizing the interviews as well as the observations into NVivo. Once I transcribed the data into NVivo, I used the word and phrase frequency functions and manually organized the data into meaningful clusters, added notes, and initiated the process of data reduction which included coding it and grouping it into meaning units for textural and structural descriptions (Moustakas, 1994; Rudestam & Newton, 2015). Data analysis intercoder agreement was assured using triangulating analysts to achieve at least a .80 intercoder coefficient agreement (Creswell, 2013; Miles & Huberman, 1994; Mouter & Vonk Noordegraaf, 2012; Patton, 1990, 2015). I determined the intercoder agreement by

independently coding the transcribed data into NVivo and hired a research assistant who independently coded the same transcripts. Once the transcripts had been coded I ran a coding comparison query in NVivo, compared our results and achieved agreement. The reliability or concordance was determined by dividing the number of agreements by the total number of agreements and disagreements (Miles & Huberman, 1994). I also followed the same procedures for thematic intercoder agreement (Creswell, 2013).

Definitions

In the context of child exposure to IPV, the following definitions spotlighted key concepts of the study:

Intimate partner violence: According to Black et al. (2011):

> Intimate partner violence includes physical violence, sexual violence, threats of physical or sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner. Intimate partner violence may occur among cohabitating or noncohabitating romantic or sexual partners and among opposite or same sex couples. (p. 37)

Intimate partner: A male or female, teen or adult person with whom one has or formerly had a close marital, dating, physical, or sexual relationship (Brieding et al., 2015).

IPV-exposed child: Was defined using Holden's (2003) taxonomy which includes in utero exposure, intervening, voluntarily or involuntarily participating, being victimized during the incidents, being a direct witness, overhearing it, observing the immediate ramifications, being involved in the aftermath, hearing of it, or thought not to be aware.

IPV victim: An adult who is currently or was formerly involved in a relationship with a person who has threatened to, or used, controlling and/ or coercive behaviors such as stalking, physical, sexual, emotional, and/ or economic abuse towards them (CDC, 2016b; Melbin, Jordan, & Smyth, 2014).

Healthcare provider: Defined by the Centers for Medicare and Medicaid Services (2006) as a trained and licensed individual or place which provides diagnostic or treatment health care related services.

Resilience: A healthy adaptive and developmental process which provides a person or a child with the ability to overcome negative life or stressful events (Masten, 1994, 2014).

Assumptions

There are several assumptions which were inherent in my study. The first assumption was that the participants, as mothers, would be able to describe the effects that exposure to IPV has had on their children. Second, I assumed that the responses to the open-ended questions would be truthful. Lastly, the study assumed that the participants would have knowledge of some of the possible indicators of resiliency. These assumptions were necessary to the study because I did not interview the children. However, several studies have indicated that the mother's descriptions of the child's reactions to IPV are consistent with those of the children and that the mother's can identify their children's risk and protective factors (Howell et al., 2010; Miller, VanZomeren-Dohm, Howell, Hunter, & Graham-Bermann, 2014; Nouer, Mackey, Tipton, Miller, & Connor, 2014; Randell, Bledsoe, Shroff, & Pierce, 2012).

Scope and Delimitations

There were several delimitations which were beyond the scope of my study. First, my study took place on a high-risk IPV population (DOHMH, 2008) which limited its transferability but I may have been able to identify patterns which could be used as variables in a larger quantitative study which could lead to generalizable results (Creswell, 2013; Patton, 2015). Furthermore, the sensitivity of the topic and the shame associated with it may have made it challenging for the participants to openly discuss their experiences and could have resulted in the participants underreporting their child's exposure to IPV (Creswell, 2013; Mbilinyi, Edleson, Hagemeister, & Beeman, 2007). Also, my study relied on the self-reporting of the mother's perception of events and the impact of IPV on the child, and this might have delimited the data (Creswell, 2013). In addition, my interviews did not reveal the role of community factors such as unemployment, poverty, and crime which could also influence the resiliency of IPV-exposed children (Breiding et al., 2014; CDC, 2008; Citizens Committee for Children of New York, Inc. [CCC], 2015; Masten, 2014). Also, most of the participants were recruited from domestic violence organizations which provided supportive services to IPV families which may have enhanced parental and child adjustment (Graham-Bermann et al., 2009; Howell, Cater, Miller-Graff, & Graham-Bermann, 2014).

The population I included was based on the predefined criteria of being a Puerto Rican mother, over 18 years of age, of an IPV-exposed child aged 6-11 years. Thus, I excluded non-Puerto Rican mothers, children, mothers younger than 18 years of age, and fathers. I did not investigate the previously applied theories or conceptual frameworks

including the cognitive-contextual framework (DeBoard-Lucas & Grych, 2011), attachment theory, social support theory (Miller et al., 2014), feminist theory (Kelly, 2009), and social learning theory (Aymer, 2008).

Limitations

The design and methodological limitations of my study related to issues of recruiting and sampling. First, I recruited 12 participants from from a geographic area identified as high risk for IPV (Fernandez-Lanier & Gilmer, 2008; DOHMH, 2008; New York City Domestic Violence Fatality Review Committee, 2014). Additionally, I used a purposive non-probability criterion sampling strategy (Creswell, 2013; Patton, 2015; Robert Wood Johnson Foundation [RWJF], 2008) which limited the representativeness of the sample (Miles et al., 2014; RWJF, 2008). Thus, my findings will likely not be transferable to other geographic locations or populations (Creswell, 2013; Miles et al., 2014). Last but not least, researcher bias, as a result of my experiential knowledge (Patton, 2015) may have influenced the participants, data collection and data analysis procedures. The measures I took to reduce limitations will be described in chapter 3.

Significance

Child exposure to IPV is significant because it impacts public health's ability to attain the overarching goal of ensuring the health and safety of society which is central to the broader ecological perspective of population health (Resnick & Siegel, 2013). My research filled an identified gap in the literature, which included limited research on Puerto Rican mothers who have IPV-exposed children (Mogro-Wilson et al., 2013) and the grouping of Hispanic subgroups into one category, by exploring the impact of IPV on

children aged 6-11 years, as perceived by their Puerto Rican mothers. I explored these factors, from a high-risk subgroup (DOHMH, 2008), which was vital to advancing public health's knowledge by raising awareness of issues which may influence resiliency through a ripple effect (Laureate Education, 2015b). Scientific evidence informed practice and aided in mobilizing developmentally as well as culturally appropriate, evidence-based programs, tailored to meet the needs of the target population (Laureate Education, Inc., 2015b). Additionally, it enhanced interdisciplinary communication, training, and collaboration for the early recognition of child IPV-exposure, culturally sensitive screening practices for mothers and the provision of needs-based referrals (Felitti et al., 1998; USPSTF, 2013). This research problem related to a real world problem and had the potential to promote positive social change as well as advocacy (Laureate Education, 2015a). Positive social changes that were consistent with this study included enhancing knowledge across various levels, informing healthcare providers on culturally appropriate ways to increase disclosure, and increasing the allocation of resources for families affected by IPV including the children exposed to it. Lastly, from a social change perspective, this study was in alignment with the core functions of public health (CDC, 2011), Healthy People 2020 objectives (U. S. Department of Health and Human Service, 2014), the WHO (2012) Global Campaign for Violence Prevention, and the CDC (n.d.) strategic direction for IPV prevention.

Summary

The topic of child exposure to IPV has come to the forefront of public health over the past few decades and is an issue that affects individuals, families, communities and

our overall society. Exploring this phenomenon for a Hispanic subgroup of Puerto Ricans and the perspective of the mothers was useful in developing culturally appropriate early interventions that influence the help-seeking behaviors of mothers and protecting the well-being of children exposed to IPV. The deleterious short- and long-term behavioral, physical, social, and environmental effects of IPV exposure on children is documented (Holt-Lunstad & Uchino, 2015; Letourneau et al., 2013; Nouer et al., 2014; Olaya, Ezpeleta, de la Osa, Granero, & Doménech**,** 2010). However, there was a gap in the literature related to IPV about factors which may uniquely influence the resiliency of children as perceived by their Puerto Rican mothers (Fine et al., 2006; Mogro-Wilson, 2013; Mogro-Wilson et al., 2013). My study was needed because a cultural mindset is vital to addressing the issue and the research on IPV-exposed children with Puerto Rican mothers was sparse (Fine et al., 2006; Mogro-Wilson et al., 2013).

Chapter 2: Literature Review

Introduction

Problem Statement

Black et al. (2011), Breiding et al. (2015) and the WHO (2002) have defined IPV as stalking, coercive tactics, physical, sexual, emotional, or economic abuse, or its threat, from one partner in a relationship to another. Family violence has affected millions of households for many years, but the effects of childhood exposure to IPV have only recently come to the forefront (UNICEF, 2006). In the United States, millions of children are repeatedly exposed to IPV (Hamby et al., 2011; McDonald et al., 2006). Exposure to or the witnessing of IPV among children can occur when they see it or the injuries from it, listen to it or hear of it but over 10 different types of exposure have been identified including when they get involved or are forced to participate (Holden 2003). Thus, child IPV exposure can occur in many ways (Holden, 2003) but up to 90% of children directly witness physical violence (Hamby et al., 2011). Worldwide about 275 million children witness IPV and its likely to be much higher because it often goes unreported, occurs in private, and is linked with "shame, guilt or fear" (Edleson, 1999a; Olaya et al., 2010, p. 1010).

Disclosure of past violence is an important part of healing (Liebschutz et al., 2008) but personal, situational, social, and cultural factors influence disclosure (Heise, 1998). Cross-cultural and other between-group differences can affect attitudes towards IPV, adherence to cultural ideals, how IPV is perceived, child-parent relationships, and help-seeking behaviors (Beauchamp et al., 2012; Dietrich & Schuett, 2013).

Women have a greater prevalence of IPV than men (Black et al., 2011; United Nations, 2010). Mothers who are battered by their intimate partners often go to great lengths to protect their children from being exposed but exposure can still occur (Edleson, 1999a; Family Violence Prevention Fund [FVPF], 2008). Battered mother's try to prevent the IPV in the presence of their children whereas the perpetrators may use the children as a means to exert their control (Louis & Johnson, 2017). Children are often caught in the middle and are the unintended victims who are "forced to live with intimate partner violence" (Edleson, 1999a; Goddard & Bedi, 2010, p. 10).

A number of studies have found that the children of battered women tend to internalize or externalize the dysfunctional behaviors to which they are exposed, and experience higher rates of abuse and neglect as they grow older (Bell et al., 2009; McCaw et al., 2007; Yates et al., 2003). IPV exposure in childhood can also lead to a range of short and long-term behavioral, physical, social and environmental challenges throughout their life (Felitti et al., 1998; Middlebrooks & Audage, 2008). Other studies have found that some children are able to overcome the adverse experiences they have been exposed to (Graham-Bermann et al., 2009; Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009).

The terms Latino or Hispanic are used interchangeably to account for a variety of ethnicities including Cubans, Mexicans, Puerto Ricans, and other cultures which are grouped into a multitude of races (Humes et al., 2011). Among Hispanic subgroups, some researchers posit that Puerto Rican's have the highest prevalence of IPV in the United States (Bassuk et al., 2006; Kaufmann et al., 1994; Roure, 2011). There are many reasons

for this. Identified risk factors associated with IPV include being a female, having young children, unemployment, and having a low socioeconomic status (CDC, 2015a). Puerto Rican's, the second largest group of Hispanic origin in the United States, are less likely to be married, are more apt to live in poverty, and have higher rates of teenage pregnancies than other Hispanic subgroups (Brown & Patten, 2016; U. S. Census Bureau, 2010). In the United States, approximately 40% of the Puerto Rican family households have children younger than 17 years of age and most of them (24%) are 9 years old or younger (Collazo et al., 2010). However, the research on how Hispanic subgroup cultural norms, values, beliefs, and attitudes (Edelson et al., 2007; White & Satyen, 2015; Yoshioka & Choi, 2005) may impact Puerto Rican IPV-exposed children (Graham-Bermann et al., 2009) is sparse (Mogro-Wilson et al., 2013). The target community was deemed high risk for IPV as a result of a combination of these risk factors (DOHMH, 2008; Fernandez-Lanier & Gilmer, 2008). Exploring this issue was vital to increasing disclosure, decreasing IPV risks and to improving the resiliency of IPV-exposed children using culture-centered approaches (APA, 2003; Morse et al., 2012). The potential positive social change aspects of my study included empowering mothers to change their help-seeking behaviors by disclosing IPV (Morse et al., 2012), influencing culturally sensitive IPV screening and referral practices among health care professionals (Sprague et al., 2012; Taft et al., 2013), and providing children with an opportunity to become productive citizens as a result of early interventions (Greeson et al., 2014; Morse et al., 2012; Sprague et al., 2012; Taft et al., 2013).

Problem Relevance

IPV is a complex multifactorial social issue which is deeply rooted in community and societal norms (CDC, n.d.). Women of child bearing age are at greatest risks for IPV (CDC, 2014; USPSTF, 2013) and this subsequently places children at risk for exposure as early as in utero (Bezruchka, 2005). Every year, millions of children (Hamby et al., 2011; McDonald et al., 2006) are exposed to IPV in many ways (Holden, 2003). The challenges associated with child exposure to IPV may include physical, behavioral, social and environmental issues that can carry over into adulthood (Felitti et al., 1998). IPV exposure may also place children at greater risks for child abuse, maltreatment and neglect (Goddard & Bedi, 2010; Hartley, 2004) and can also influence their coping mechanisms due to the stress of witnessing parental violence (Bai & Repetti, 2015). Yet, researchers have also identified several protective factors, such as internal resources and external assets, which may make some children more resilient than others (Fergus & Zimmerman, 2005; Masten, 1994, 2014; Rutter, 1985).

The following sections of this chapter include a description of the strategies used for searching the literature including the library databases, search engines, word combinations, and Boolean operators used. Additionally, it includes the theoretical foundation, a detailed literature review which focused on the key concepts, a summary and a conclusion. As a result of the lack of available literature on the Puerto Rican mothers' perceptions of how exposure to IPV affects their children aged 6 to 11 years, the literature review integrated various aspects and content of previous research, as they related to this study which used resilience theory and a phenomenological approach.

Literature Search Strategy

My literature review included an exploration of what is known about the incidence and prevalence of child exposure to intimate partner violence including risk and protective factors which may impact the resiliency of IPV-exposed children aged 6 to 11 years. Additionally, it was an exploration of the multifactorial issue of child exposure to IPV among the subgroup of Puerto Rican's including what is known about their beliefs and values with regards to IPV and subsequent child exposure to it. The studies in this review focused on literature published within the last five years accessed through multiple online databases including Academic Search Complete, CINAHL Plus, Cochrane, MEDLINE, PsychInfo, SocIndex, and Google Scholar. Additionally, books and articles were also obtained through citation chaining and some relevant peer-reviewed articles and books from prior years were also included. I searched using a combination of keywords, concepts and Boolean operators included *intimate partner violence* AND *child exposure*, *domestic violence* AND *child witnesses* OR *exposure*, *intimate partner violence* AND *school-age children*, *Latino* OR *Hispanic children* AND *domestic violence exposure*, *domestic violence* OR *intimate partner violence* AND *Puerto Rican children*, *Puerto Rican* OR *Hispanic mothers* AND *domestic violence*, *mothers* AND *domestic violence*, *Puerto Rican's* AND *domestic violence*, *culture* AND *child resiliency*, *child resilience* AND *domestic violence*, *Hispanic* OR *Latino child resilience* AND *domestic violence*, *school age child resilience* AND *domestic violence*, *Latino children* AND *resilience to trauma*, *school-age children* AND *resilience to trauma*, *resiliency theory* AND *children*, *resiliency theory* AND *adaptation*.

Theoretical Foundation or Conceptual Framework

Resilience Theory

I explored this phenomenon using the theoretical framework of Masten's (1994) resilience theory because it provided an ecological context to child care and protection (Barron et al.2015; Garmezy et al., 1984; Masten, 1994). Resilience theory focuses on ordinary developmental, adaptive processes which are inherent human capabilities and how they can best be protected (Masten, 1994, 2001). It is derived from a combination of exposure to adverse events and the ability to spring back (Masten 1994; Western Australian Centre for Health Promotion Research, 2010). It also provided a socioecological perspective for examining the multilevel isues associated with child exposure to IPV (CDC, 2015b; Masten et al., 1990; WHO, 2010).

I utilized resilience theory as a preliminary theoretical framework to examine risk and protective factors including assets and resources which influenced coping mechanisms in the face of exposure to traumatic events (Fergus & Zimmerman, 2005; Masten, 1994; Rutter, 1985; Western Australian Centre for Health Promotion Research, 2010). I also used the theoretical framework to guide the research process which included developing the interview protocol questions, to focus the study's design (Creswell, 2013) and to spotlight concepts as well as potential relationships (Maxwell, 2005). Resilience theory played a vital role in exploring individual, cultural and community factors which influences IPV risks, resiliency of victims and their families, changes in social norms and could subsequently decrease child IPV exposure (Dahlberg & Krug, 2002; WHO, n.d.).

Key Concepts

The concept of resilience is rooted in psychology and in Latin the word means to spring back (Masten, 2014). From a general systems theory perspective, von Bertalanffy (as cited in Masten, 2014) referred to resilience as a process of restoration to a functional state of equilibrium after having been disrupted. Initially, it was thought that individuals who persevered despite having been in high-risk environments were invulnerable (Garmezy, 1971), but Masten (1994) found that resilience is an ordinary process of positive adjustment which leads to positive outcomes despite exposure to adverse risks or life events. The phenomenon of resilience is described by Fergus and Zimmerman (2005) as the recovery of individuals who have experienced adverse events and by Masten (1994) as a positive adaption to stressful adverse events. However, it's important to note that resilience varies depending on the content and context of risks, protective factors, individual experiences, and by functional as well as developmental patterns (Fergus & Zimmerman, 2005; Masten, 1994).

Masten (1994, 2014) posits that there are intrinsic and extrinsic individual, family, and community factors which play a role in helping individuals overcome harsh conditions and thrive in spite of their surroundings (Barron et al., 2015; Heise, 1998). Masten (1994, 2014) also integrates the concept of social support which was an integral part of this dissertation because social support may act as a protective factor for IPV-exposed children (Howell et al., 2010; Kelly, 2009; Letourneau et al., 2013; Nouer et al., 2014). Thus, the construct of resilience includes risks, vulnerability, protective factors,

and adaptation and all are applicable to the research on children who have been exposed to intimate partner violence.

Literature Review Related to Key Concepts

Prevalence and Incidence of Intimate Partner Violence

IPV is a global public health crisis which has reached epidemic proportions (United Nations, 2010; WHO, 2013). IPV is a complex multifactorial issue which influences victims, families and communities (CDC, 2015a; Sokoloff & Pratt, 2006). The literature reflects that women are more likely to become victims of IPV than men (Black et al., 2011; Truman & Morgan, 2014; United Nations, 2010; WHO, n.d.) and that women of childbearing age are at greatest risk (CDC, 2014; USPSTF, 2013). Globally, approximately 70% of females, 15 years of age and older, have been victims of IPV in the form of physical abuse, sexual violence, or both in their lifetime (Head, Zweimueller, Marchena, & Hoel, 2014; Tjaden & Thoennes, 2000; WHO, 2001). In the U.S., more than 35% of women, which equates to over 42 million women, have been victims of IPV at some point in their lives (Black et al., 2011; CDC, 2014). Data from the National Intimate Partner and Sexual Violence Survey (NISVS) conducted in 2010, noted that the lifetime victimization prevalence rates by intimate partners reported by the female participants, 18 years of age and older, of non-rape sexual violence, rape, physical violence, stalking, and psychological aggression including coercive tactics, were 16%, 9%, 33%, 11%, and 48% respectively (CDC, 2014). Also, in the U. S. almost 29% of men, aged 18 and over, reported that they had been victims of IPV (Black et al., 2011). NISVS data for male victims of IPV reflected lifetime prevalence rates of non-rape

sexual violence, physical violence, stalking, and psychological aggression including coercive tactics, were 8%, 14%, 2%, and 49% respectively (CDC, 2014). Unfortunately, the NISVS doesn't inquire about the parental status of the IPV victims or child exposure. Additionally, the lack of inclusion of women less than 18 years of age is a NISVS limitation particularly since teenagers between the ages of 15 and 17 had birth rates of 17.4 per 1,000 women in 2010 (Kost & Henshaw, 2014) and have an increased vulnerability to IPV (Miller et al., 2007).

Child IPV Exposure Rates

Children who are exposed to IPV are the innocent, silent, forgotten, and unintended victims (Goddard & Bedi, 2010). Until recently, underreporting, lack of surveillance, inconsistent data collection procedures, variations in the definitions of IPV, and the timeframes analyzed made determining child IPV exposure incidence and prevalence rates challenging (Breiding et al., 2015; UNICEF, 2006). These factors influenced issues associated with decreasing risks and enhancing protective factors to child IPV exposure (Hamby et al., 2011; Mbilinyi et al., 2007; DOHMH, 2008; Nouer et al., 2014). While some of the mentioned barriers still exist, great strides have recently been made including the development of a taxonomy of up to 10 different types of child IPV exposure (Holden, 2003) and a child stress experience taxonomy (National Scientific Council Center on the Developing Child at Harvard University, 2007).

Research which focuses on child IPV exposure incidence and prevalence rates has increased over the past few years but some limitations still exist. For example, Smith & Farole (2009) evaluated state court data on 3,750 cases of IPV in 16 large urban

communities and found that 50% of the incidents were witnessed; children were present 36% of the time and that 22% of the children were direct witnesses to the violence. However, the focus of the study was on the outcomes of the cases and demographic data on the victims or defendants wasn't included. Also, it's important to note that 40% of family violence isn't reported primarily because the violence is viewed by the victims as private (Durose et al., 2005). Such findings are consistent with some of the cultural values of Puerto Rican's specifically familism, fatalism, and marianismo which may prompt them to seek help from informal supports because the use of formal supports clashes with their cultural beliefs (Gillette, 2011).

Additionally, in their research, McDonald et al. (2006) noted that among the 22% of married or cohabitating couples who reported IPV in the past year, 60% had an average of two children living in the household. Among the participants who reported one episode of severe violence in the past year, 63% had children living in the dual-parent household. McDonald et al.'s (2006) estimate of approximately16 million IPV-exposed children would likely be much higher if one were to include the multiple types of environments where child IPV exposure could occur. For example, Zill's (2014) analysis of data from the 2011-12 National Survey of Children's Health found that children residing in divorced or separated female headed households were seven times more likely to have witnessed IPV and those living with never married mothers were six times more likely to witness IPV when compared to children living in married households. Furthermore, McDonald's et al. (2006) measure of 'IPV within the last year'

does not take into account children who may have been exposed prior to the previous year, i.e., it does not offer a lifetime percentage of child exposure to IPV.

In addition to the National Survey of Children's Health mentioned above, NCVS (Catalano et al., 2009) data reveal that almost 40 percent of households with a female IPV victim included children less than 12 years of age living in the home. However, NCVS data does not measure exposure to IPV but is useful in determining the number of children under age 12 who were living in the household (Catalano et al., 2009). Also, NatSCEV data has been used to assess past year and lifetime incidence and prevalence rates of exposure to violence as well as other factors in children 17 years of age and younger (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). In 2008, NatSCEV data indicated that 25% of the participants had witnessed incidents within the past year which increased to 38% in their lifetime but the trend was attributed to an increase in exposure to community violence as they aged (Finkelhor et al., 2009). Family violence, which included IPV, was categorized as a form of indirect exposure and incidence and prevalence rates remained constant at six to 11% across all age groups (Finkelhor et al., 2009).

On the other hand, Hamby et al. (2011) also used NatSCEV data but focused on child exposure to IPV and other types of family violence. They found that the most common types of child IPV exposure were directly witnessing the violence, hearing it, hearing of it, or experiencing its after-effects. Past year rates of child IPV exposure to physical assaults and emotional IPV were seven and six percent but increased to 16 and 18% in their lifetimes respectively (Hamby et al., 2011). Compared to teenagers, children

between six to nine years of age had the second highest lifetime percentages of having witnessed verbal threats (7.6%), displaced aggression (13.7%), physical (10.5%) and severe physical abuse (5.7%). Nonetheless, the lifetime prevalence of exposure to IPV among school age children has been conservatively estimated to range from four to six percent (Hamby et al., 2011) but past-year exposure increased their risks of lifetime exposure to violence and polyvictimization (Finkelhor et al., 2009).

Co-occurrence of Child Abuse & IPV

Evidence exists that children who are exposed to IPV are at greater risk for child abuse and neglect (Appel & Holden, 1998; Edleson, 1999a; Hamby et al., 2010; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). Abuse, maltreatment or neglect of children can occur through a variety of ways and/or can be a second simultaneously occurring form of violence in the home (Goddard & Bedi, 2010; Hartley, 2004). Child maltreatment may occur from the victim, the perpetrator, or as a result of the child intervening in the incident or being caught in the middle (Appel & Holden, 1998; Edleson, Mbilinyi, Beeman, & Hagemeister, 2003; Hartley, 2004). Family stability, their relationship to the abuser, and the degree of violence all play significant roles in whether a child will intervene (Analytic Sciences, Inc., 2002; Edleson, Mbilinyi, Beeman, & Hagemeister, 2003). Children are more likely to physically intervene and place themselves at risk for injury in high levels of violence (Edleson et al., 2003). According to Edleson (1999b) in "...30- 60 % of families where either child maltreatment or adult domestic violence is occurring one will find that the other form of violence is also being perpetrated" (p. 136). The variable determinants of the co-occurrence of child abuse and

neglect with IPV include, and are not limited to, having witnessed IPV as a child, parental stress and disruptive parenting which may lead to punishment and abuse, parental substance abuse, and parental psychopathology such as anxiety, depression and post-traumatic stress disorder (Carlson, 2000; Strauss, 1991). Needless to say, dose response relationships have been linked to a multitude of behaviors as possible coping strategies (Felitti et al., 1998).

Legal Issues

In the United States, each state sets its own definition of child abuse and neglect, but they are bound to meet the minimum federal guidelines as defined by the Family Violence Prevention and Services Act (2003). The federal government defines child abuse and neglect as "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; ... or which presents an imminent risk of serious harm" (Child Welfare Information Gateway, 2008, p. 2). The major types of child abuse are categorized as the physical, emotional, sexual abuse, or neglect of a child who is less than 18 years of age and not considered an emancipated minor (Child Welfare Information Gateway, 2008). Neglect is the parent or caregiver's inability to meet the child's basic physical, educational, medical, and/ or emotional needs (Child Welfare Information Gateway, 2008).

Mandatory Reporting. Much controversy exists regarding the need to report children exposed to IPV to Child Protective Services (Groves, Augustyn, Lee, & Sawires, 2004). Many states have mandatory reporting procedures for children who live in IPV households regardless of their exposure (Hagemeister, 2000; Groves et al., 2004).

Mandatory reporting is based on the assumption that parents are neglectful of their children's needs and have control over their exposure to IPV (Groves et al., 2004). Hartley (2004) and Alaggia, Gadalla, Shlonsky, Jenney, and Daciuk (2015) noted that in cases of IPV where males had been the perpetrators, the mothers were frequently charged with failure to protect because of their societal role as the primary caregiver.

Mandatory reporting laws influence Hispanic mothers from disclosing IPV, seeking formal assistance and public health prevention efforts (Alaggia et al., 2015: Groves et al., 2004; Hartley, 2004; Kelly, 2009; Rhodes, Cerulli, Dichter, Kothari, & Barg, 2010). In their mixed methods study, Alaggia et al. (2015) found that the expectations of CPS that the mother leave the abuser didn't take into account the emotions that mothers encounter over possibly losing their children or their religious, and cultural beliefs regarding separation or divorce. They noted that there were a greater number of child exposure to domestic violence (EDV) cases referred for non-whites and that the cases remained open for longer timeframes when compared to maltreatment cases. Furthermore, community referrals made were primarily victim and not child focused and rarely involved the perpetrator. The issue of mother-blaming is inherent in domestic violence mandatory reporting laws which are counter-effective and may actually cause more harm for the victims and their families than good.

Health care reporting. Female IPV victims have been known to have numerous encounters with healthcare providers. Accordingly, in the United States, over 30% of IPV victims incur injuries which require medical attention (CDC, 2003; Kramer, Lorenzon & Mueller, 2004). Healthcare providers are also mandatory reporters for EDV and should

be routinely screening women of childbearing age and providing them with referrals as per the USPSTF (2013) recommendations. However, Alaggia et al. (2015) noted that health care workers had made seven percent of the referrals to CPS as compared to 50% which were made by law enforcement officers. The literature reflects multiple healthcare provider barriers related to IPV screening and referral processes which include, but aren't limited to, decreased knowledge of IPV, fear, patient noncompliance with recommendations, and time limitations for screenings (Sprague et al., 2012; Taft et al., 2013).

The existing evidence related to the reduction of IPV as a result of screening and providing referrals is controversial. For example, Bair-Merritt et al. (2010) and Taft et al. (2013) found evidence which supports the USPSTF (2013) recommendations but Hegarty et al. (2013) and Klevens et al. (2012) research didn't. However, the cultural values of familism and collectivism among Puerto Ricans may influence IPV victims in their disclosure to healthcare providers, which suggests that they should be approached in a non-threatening culturally appropriate manner when screened (Dietrich & Schuett, 2013; Mogro-Wilson, 2013). Indeed, in their grounded theory qualitative study; with Spanish-speaking Latina participants, Ahrens, Rios-Mandel, Isas, and del Carmen Lopez (2010) found that lack of knowledge, embarrassment, fear of repercussion, traditional gender roles, and the values of respect and familism all played a role in disclosing IPV. The impact that child exposure to IPV may have had on disclosure wasn't explored in this study though the participants did discuss how they educated their children using their own experiences. Thus, health care personnel may have better opportunities for revealing

IPV by screening Hispanic mothers in pediatric settings, for example, in the context of educating them (Randell et al., 2012). The provision of education should be based on an assessment of the mother's stage of readiness, using the transtheoretical model, for setting realistic goals (Prochaska, Redding, & Evers, 2002; Randell et al., 2012). According to the National Center for Children Exposed to Domestic Violence (NCCDEV) (2006) educating, screening, supporting the caregiver, providing interventions that enhance the safety and security of children as well as strengthen the relationships between children and their primary caregivers are the key to minimizing the long-term damage of IPV on children (Randell et al., 2012).

Resilience in IPV-exposed Children

Most of the resiliency literature focuses on the adult victim, child exposure to abuse and neglect, community violence, the parent-child relationship of IPV exposed preschool children and shelter-based samples (Gewirtz & Edleson, 2007; Howell, 2011; Howell et al., 2010; Yates et al., 2003). Many factors influence the risks and resiliency of IPV-exposed children including, but not limited to, the child's temperament, self-esteem, social skills, level of depression, parental stressors as well as their parental relationships and social supports (Gewirtz & Edleson, 2007; Graham-Bermann et al., 2009; Huth-Bocks *&* Hughes, 2008; Martinez-Torteya et al., 2009). Additionally, the type of children's exposure, frequency and type of violence, their level of involvement, age, parental relationships, family stability, the co-occurrence of child abuse or neglect, the community, and environment all play a role in the IPV-exposed child's adjustment or lack thereof. Lastly, a child's response to IPV exposure will be based on his/her

appraisal, perceived control, and the meaning they've attached to the conflict (DeBoard-Lucas & Grych, 2011; Edleson 1999a; Kernic et al., 2003).

Effects of Child IPV Exposure

Children are not given the option of choosing the life, family, and environment into which they are born. Thornton (2014) posited that children exposed to IPV are frequently the unheard, innocent and restricted victims of the situation particularly when they're too young to articulate their feelings and their unmet needs can emotionally overwhelm them. Additionally, a number of studies have found that, as early as infancy, the children of battered women have higher rates of internalizing or externalizing behaviors and of abuse and neglect (Bell et al., 2009; McCaw et al., 2007; Yates et al., 2003). Some researchers posit that boys are more likely to externalize behavior problems whereas girls may be more likely to exhibit internalization (Ballif-Spanvill, Clayton & Hendrix, 2007; Kerig, 1998; Yates et al., 2003). Yet, in their research studies Idemudia and Makhubela (2011) and Sternberg, Baradaran, Abbott, Lamb, and Guterman (2006) have found inconsistencies in the evidence for gender differences. Kerig's (1998) cross-sectional quantitative study on child exposure to mostly verbal conflicts between their parents found statistically significant results that boys were more likely to externalize their behaviors whereas girls were more likely to engage in self-blame resulting in internalization. However, the participants were primarily middle-class Caucasians intact families which influenced its generalizability to other populations. Furthermore, the cross-sectional design and reliance on retrospective self-reported measurements limits the internal validity of the study. Nonetheless, some children are able to overcome emotional

and behavioral challenges despite multiple risks and exposures to adverse life events. In their longitudinal study which included children exposed to environmental risks including poverty, disadvantaged neighborhoods and stressful life situations, Flouri, Midouhas, Joshi and Trzavidis (2015) positive parent-child relationships including involvement were strong moderators to child behavioral problems across the trajectory. In other words, warm and nurturing parents can moderate the effects of disadvantage neighborhoods, poverty and stressful life events.

Coping

Several studies have shown that maternal stress, due to IPV during pregnancy, results in the transmission of increased levels of cortisol to the fetus placing them at risk for low birth weight and undernutrition which predisposes children to chronic diseases later in life (Bezruchka, 2005; Felitti et al., 1998; Gluckman et al., 2010; Levendosky, Leahy, Bogat, Davidson, & von Eye, 2006). High levels of cortisol in children have been linked to a dysregulation of the hypothalamic-pituitary-adrenal (HPA) stress response which may influence a child's internal coping resources (Bai & Repetti, 2015). Coping challenges can lead to toxic stress which can result in permanent brain damage and affect the body's immune response making them more susceptible to infections and chronic diseases (Carrion, Weems, & Reiss, 2007; Middlebrooks & Audage, 2008; National Scientific Council Center on the Developing Child at Harvard University, 2007).

In contrast, Levendosky et al. (2011) longitudinal study utilized a diverse sample of low-income mothers, who had experienced depression and IPV during pregnancy and after childbirth, to assess the stability of attachment in their children at ages one and four.

They used a two and four group classification and found that curves in IPV trajectories influenced attachment. They concluded that about 50% of the children demonstrated secure attachment from age one to four which is a developmental sign of cognitive and emotional regulation over time (Levendosky et al., 2011). The ability to self- regulate serves as a protective factor which enhances resiliency in IPV-exposed children (Benavides, 2015). Additionally, since exposure to IPV doesn't follow linear models (Levendosky, Bogat, Huth-Bocks, Rosenblum, & von Eye, 2011), the physiological reactivity of children may fluctuate thereby promoting their resilience as a result of periods of positive emotion (Obradovíc, 2012). For example, in their cross-sectional quantitative study, Howell et al. (2010) utilized resilience theory to assess the individual characteristics of prosocial skills and the emotional regulation of preschool children whose low-income mothers were victims of IPV in a primarily African-American sample of community and shelter-based participants. The prosocial skills and emotion-regulation in the children were influenced by the mother's mental health, the child-mother relationships and the severity of IPV. Children who had positive maternal relationships and mothers who had experienced less severe episodes of IPV were more resilient in terms of their prosocial skills and emotion-regulation (Howell et al., 2010). However, the study didn't explore whether any of the children had been exposed to IPV, was based solely on the mother's self-reporting and had a small sample size which may influence Type II errors. Lastly, unexplored extrinsic factors may have accounted for some of the variabilities in the outcomes. These were important considerations for my research

because the mother-child relationship was explored based on their developmental stage and the relationships they formed.

In their phenomenological study, using social learning theory, Aymer (2008) explored the coping strategies of 10 adolescent male participants who had been exposed to IPV. The teenagers had all witnessed varying degrees of IPV including physical and economic abuse, and experienced poverty, drug abuse including alcohol, housing instability, and overcrowding which are risk identified factors for IPV (CDC, 2008). Suicidal and homicidal thoughts, fear, confusion, anger, and depression emerged as common emotional themes among nine of the participants. Getting involved in sports, church or after-school activities helped some of them cope with their emotions whereas others used unhealthy coping strategies such as dealing drugs or fighting in school. Interestingly enough, all of the participants sought counseling and had ongoing relationships with their mothers. Six of them were Puerto Rican and noted that when they questioned their mother's about staying in the abusive relationship the mother's verbalized their commitment to the relationship and the importance of keeping the family together. Also, some IPV-exposed children have different mental health needs, even when IPV occurs before they are born, and more health care system encounters than those who aren't exposed (Olaya et al., 2010; Rivara et al., 2007). In their quantitative study, Olaya et al. (2010) found that the primarily European children who were exposed to IPV had a higher amount of physical and mental health impairments than non-IPV exposed participants. Interestingly enough, Olaya et al. (2010) also noted that the social skills and self-esteem of the child participants didn't differ between the exposed and non-

exposed children which is indicative of a protective mechanism (Benavides, 2015). School-age children need to develop social skills in order to feel competent. The evaluation of the mother's perceptions of their IPV-exposed child's social skills was vital to determining the types of interventions that were best suited for them.

Cultural Risk and Protective Factors

Among Puerto Rican's collectivist cultural norms (Yoshioka & Choi, 2005) and the cultural values of familism, pride, sympathy, respect, machismo (male dominated gender roles), and marianismo (female modesty gender roles) (Edelson et al., 2007; White & Satyen, 2015) may uniquely influence the risks and resiliency of their IPV exposed children (Graham-Bermann et al., 2009; Mogro-Wilson, 2013; Mogro-Wilson et al., 2013). Belief systems, such as the honor code and the importance of maintaining cultural roots, make it more likely that Puerto Rican female IPV victims will be more tolerant of IPV and the perpetrator thereby increasing the risks of the IPV exposed child (Dietrich & Schuett, 2013). On the other hand, the Puerto Rican cultures strong orientation to family may also act as a buffer for Hispanic children exposed to IPV. Dietrich and Schuett (2013) found that the Latino cultural values of familism, which upholds honor, influence the help-seeking behaviors of Puerto Rican women. Lastly, Puerto Rican mothers also place a high level of importance on their relationships with their children including going to great lengths to avoid emotionally harming them (Fine et al., 2006; Mogro-Wilson, 2013). Their values of marianismo are a traditional cultural perspective of treating others with kindness, sympathy and humility has a strong influence on parenting behaviors (Mogro-Wilson, 2013).

On the other hand, Milan and Wortel (2015) cross-sectional study examined the process of family obligations [FO] values, in mother and adolescent daughter dyads, to assess whether they contributed to risks or served as a protective factor in a sample of mostly Puerto Rican (58%) participants. Their findings indicated that adverse life events contributed to depressive and other mental health symptoms when girls had high or moderate FO but the association wasn't consistent. However, Milan and Wortel (2015) findings were indicative that girls with high FO and an increased number of adverse life experiences were more symptomatic than girls with high FO's and less exposure to adverse events. They hypothesized that exposure to fewer adverse events may act as a protective factor for risky behaviors among adolescent girls with high FO. FO is an issue that was explored in my study because it would have influenced how the mother's perceived or measured how IPV exposure had affected their children.

Social support. One of several critical protective factors that has been shown to have a positive influence on the resiliency of a child exposed to IPV is social support (Osofsky, 1999; Howell et al., 2014). Researchers have noted that social support influences self-esteem, coping skills and mental health (Holt-Lunstad & Uchino, 2015) in both the parent and the child (Letourneau et al., 2013; Muller, Goebel-Fabbri, & Diamond, 2000). In their study on Puerto Rican parent-child dyads, Mogro-Wilson et al. (2013) used existing baseline survey data and found that increased cultural connections and social networks contributed to the behavioral problems of IPV and substance abuse disorder [SUD] exposed children. This is in contrast to various other studies which report enhanced adaptation among children exposed to IPV as a result of strong parental bonds

and social support networks (Gewirtz & Edleson, 2007; Graham-Bermann et al., 2009; Kelly, 2009). However, it may be that children raised in an environment with IPV and a parent who has a SUD are more likely to experience higher levels of violence, adopt family responsibilities, be socially isolated, and have behavioral problems (Velleman & Templeton, 2007). Their parents may purposefully avoid being with others due to social embarrassment or shame (Velleman & Templeton, 2007) whereas Puerto Rican IPV victims tend to seek support from their family members (Mogro-Wilson, 2013). Thus, parental drug abuse may result in disruptive parenting which would influence resiliency and adaptive behaviors (NCCEDV, 2006). Miller et al. (2014) noted that social support from family members buffered the behavioral problems of the IPV exposed children but didn't influence the types or frequencies of the IPV incidents or the mother's adjustment. However, Miller et al. (2014) and Mogro-Wilson et al. (2013) didn't detail how the relationships were supportive to the children or if the mother's had other supportive networks which my research study integrated. Furthermore, my study explored the mother-child relationship, other role models and the utilization of community resources as they may have played a role in fostering resiliency.

In their cross-sectional study, using two-wave survey data, Nouer et al. (2014) found that mothers who had IPV exposed children less than 18 years of age living with them were more likely to leave their abusive partners than mothers who didn't have children less than 18 years of age living with them. The role that social support may have played in the mother's decision-making wasn't explored but their concern for their children was evident and this is consistent with Kelly (2009) who noted that, among

Latina immigrant survivors of IPV, their role as trusting mother's influenced their decisions to eventually seek formal help for their families. Their conclusions also coincide with the Mogro-Wilson et al. (2013) findings of an inverse relationship between child behavioral problems and parental reinforcement. In their study, Fine et al. (2006) noted that Puerto Rican mothers feel responsible for maintaining the stability of the home for their children and protecting them. Despite this, they also feel a duty to resist by insisting on dignity and respect particularly when children are witnessing the violence. Unfortunately, in their qualitative study in Spain, Izaguirre and Calvete (2015) found that one of the themes that emerged was that the IPV-exposed children developed adult roles which included being violent towards their mothers. Interestingly enough, five of the children who showed signs of resiliency had mothers who took the time to talk with them after the IPV incidents. Perhaps the parent-child post violence interactions provided a supportive emotional connection which promoted the well-being of the child (Newland, 2014). Nonetheless, their findings reinforced the importance of my being flexible to exploring unexpected themes and of having resources to support the study participants.

On the other hand, in their quasi-experimental cross-sectional study, Aysa-Lastra, Rojas, Dillon, Duan, and De La Rosa (2012) utilized traumatic bonding theory to assess whether family bonds served as a protective factor in preventing lifetime IPV in a sample of Latina mother-daughter dyads. Their hypothesis that long lasting relationships with family members served as a protective factor against lifetime IPV was statistically significant. The author's attributed their findings to the value of familismo as a protective factor particularly in caring mother-daughter and mother-father relationships. However,

the participants originated from a study, initially derived using snowball techniques, which focused on the risks and possible protective factors for the transmittal of drug dependency behaviors across generations from mothers to daughters. Furthermore, they were primarily Cuban (48%), foreign born, and had low levels of acculturation. These factors may influence the participant's perceptions of IPV, family expectations and their roles within the family which reiterated the importance of exploring Hispanic subgroup values and how they may have influenced the resilience of children based on their parental relationships.

Also, in their qualitative study, Pernebo and Almqvist (2014) evaluated the experiences of IPV-exposed pre-school children who participated in group treatment interventions. Themes which emerged from the children included joy, self-motivation, physical and emotional safety, building relationships with peers, being heard, and the development of new skills. The authors of this study did not provide an explanation as to how the themes emerged and whether interrater reliability was part of the data analysis process. Nonetheless, I was open to a variety of emergent themes that promoted the resilience of children based on their level of development.

In their narrative study, Izaguirre and Cater (2016) used social support theory to explore the relationship between the perceptions and experiences of school-age children exposed to IPV and how they talked about it with others using semi-structured interviews. The researchers used social support as a construct to presume relationships, which evolved later in the study, into separate bins (Miles et al., 2014) of two groups of children which included children who expressed their feelings and those who preferred

not to talk about them (Izaguirre & Cater, 2016). Among the children who used social support as a coping mechanism. Izaguirre and Cater (2016) noted that most talked to professionals, parents, and their peers about their experiences and they all perceived it as helpful. In contrast, children who sought social support from their fathers who were the perpetrators discussed feeling more distressed afterwards because they refused to accept responsibility for the incidents and very few of the child participants discussed approaching their mothers (Izaguirre & Cater, 2016). However, the cross-sectional design, the lack of triangulation and the fact that these children were in therapy at the time of the study are limitations. Thus, as I explored mother-child relationships I also ascertained if any of the participants were discussing the incidents with their children particularly since this may act as a protective factor. Additionally, it was vital to empower the participants to openly discuss their experiences by ensuring that a trusting relationship had been established since many of them blame themselves for their child's exposure.

Help-seeking behaviors. As victims of IPV, mothers find themselves in a position to make difficult decisions that influence the public and private lives of their children (Kelly, 2009). However, the literature reflects that children can influence the decisions of Hispanic and non-Hispanic mothers in abusive relationships (Kelly, 2009; Rhodes et al., 2010). Victims of IPV, who are mothers, encounter unique motivators which may conflict with their cultural values and beliefs as well as their desire to keep their family unit together to minimize disruptive changes in the lives of their children (Amanor-Boadu et al., 2012; Kelly, 2009; Randell et al., 2012; Rhodes et al., 2010). In their study, Rhodes

et al. (2010) found that children were a source of support for mothers during and after violent incidents but the dysfunction created emotional distress as a result of instability and lack of security in the IPV-exposed children (Thornton, 2014). Additionally, in their grounded study, Randell et al. (2012) found that the mother's experiences with the effects that IPV exposure had on their children enhanced their self-efficacy and acted as a catalyst for seeking assistance. Exploring the potential help-seeking sources of motivation, for mother's who are victims of IPV, is vital to providing culturally appropriate tailored interventions that focus on educating them and enhancing the well-being of IPV-exposed children (Randell et al., 2012; Rhodes et al., 2010).

In their phenomenological study, DeBoard-Lucas and Grych (2011) sought to investigate how children perceived the violent occurrences among their caregivers. From a social support perspective, their findings indicated that children had a multitude of behavioral responses to IPV. Among the pre-adolescent participants, 50% noted that they would leave the room during the incidents and approximately 33% of the children reported seeking help by calling the police, a friend or a family member. Surprisingly, the main concern of the children was for the safety of their parents but not about the future of the relationship. Such findings may indicate that IPV-exposed children may experience hope, which has been described as a protective factor (Benavides, 2015), that the termination of the relationship would end the violence and provide a sense of stability. Exploring whether mothers view their Puerto Rican IPV-exposed child's emotion-focused responses, such as leaving the room, or problem-focused responses such as

seeking assistance, as a risk or protective factor was an important consideration in my study.

Relevance of Phenomenology to this Study

Phenomenology has been used to study some of the issues associated with child exposure to IPV but, among the few studies located, none have explored the Puerto Rican mother's perceptions of their children's, aged 6-11 years, exposure to IPV. For example, De-Board and Lucas (2011) used phenomenology to assess the perceptions and reactions of school-age children exposed to IPV. While the study was effective in exploring the perceptions and reactions of the children, which has clinical implications for prevention, there were sample size limitations which limited comparisons. On the other hand, Kelly (2009) used a phenomenological approach to explore the decision-making processes of low-income Latina immigrant mothers who were survivors of IPV. The study had clinical implications for health care provider approaches to enhancing disclosure but didn't explore the extent of child exposure to IPV or their resiliency. Additionally, Aymer (2008) used phenomenology to explore the coping responses of adolescent male participants exposed to IPV. Their findings reiterated the importance of using a socioecological perspective when exploring the phenomenon but didn't assess how culture or ethnicity may have influenced the participants coping mechanisms. Pernebo and Almqvist (2014) utilized phenomenology to evaluate a group therapy program for young children exposed to IPV. Thus, while effective, the focus of this study was to evaluate the treatment program as perceived by the children. Last but not least, Izaguirre and Calvete (2015) used phenomenology, to interview mothers in Basque Country, Spain

and ascertain their perceptions of their child's reactions to IPV exposure, the child's victimization, the consequences of exposure, their aggressive behaviors towards their mothers, and the actions taken by the mothers during violent episodes. The participants had children between one and 27 years of age and it wasn't clear from the study when and what type of exposures occurred. While the author's found that some of the IPV-exposed children showed resilience, it was defined in terms of their intervening in violent incidents which according to DeBoard-Lucas and Grych (2011) ranges in children based on their perceptions.

In reviewing other approaches, I considered using a case study or a narrative approach because they were used to attain detailed information on the lives of one or more cases. Each can have a specific focus but can be resource-intensive and time-consuming (Creswell, 2013). Additionally, as I explored my research problem, questions, purpose and the literature I realized that these approaches didn't provide a good fit (Creswell, 2013: Miles et al., 2014). I also felt that they would not have as much of an impact on informing practice as a phenomenological approach would be based on the identified gaps. The relevance of phenomenology to my study was that it can be used to focus on the subjective lived experiences of Puerto Rican mother's in relation to the phenomenon of their child's exposure to IPV and their objective commonalities (Creswell, 2013; Patton, 2015). My findings were that the approach best fitted the need to explore the phenomenon and was in alignment with the research questions, topic, and purpose of the study. Examining the "what" and "how" of the mother's perceptions of their child's experiences, using multiple types of data collection strategies, allowed me to

holistically combine the data into themes using horizonalization to develop clusters of meaning (Creswell, 2013; Moustakas, 1994). Furthermore, it would likely make a significant contribution to the existing research, would provide opportunities for additional exploration, and would potentially contribute to practice based on the identified gaps in the literature.

The central concepts of the phenomenon of resilience, for the *Effect of Intimate Partner Violence on Children of Puerto Rican Women* study, were based on the psychosocial developmental stages of primary school-age children, aged 6 to 11 years (Erikson, 1993). Positive social interactions play a key role in the child's, aged 6-11 years, ability to develop confidence (Erikson, 1993) which is an adaptive system that promotes resilience (Masten, 2001, 2014). The central concepts of resilience for the IPV-exposed child aged 6-11 years were defined with regards to protective processes which impact adaptation (Masten, 1994, 2014). Such protective factors were viewed in terms of internal assets and external resources (Masten, 2007) at the individual, interpersonal and community levels (CDC, 2015b).

Internal Assets

For this study, self-regulation was defined as the child's ability to cope with stress and confidently complete tasks based on their developmental stage (Gillespie et al., 2007; Khanlou & Wray, 2014; Masten, 2007). Coping related to the child's abilities to use adaptive problem-focused strategies to appraise external or internal stressors (Gillespie et al., 2007; Masten, 2001). Hope was the child's belief that goals can be accomplished (Gillespie et al., 2007; Masten, 2007). Lastly, social competence referred to the child's

capacity to engage in prosocial relationships with positive networks of friends and family members (Masten, 2001, 2007).

External Resources

External multilevel systems play a role in the development of resilience **(**Gewirtz & Edleson, 2007; Masten, 2007). Thus, a parent(s) is defined as having a supportive quality relationship which is based on a secure attachment, parental involvement, and communication (Khanlou & Wray, 2014; Masten, 2001, 2007). Another external resource are role models who were supportive and encouraging adults outside of the immediate family (Khanlou & Wray, 2014; Masten, 2007, 2014). Lastly, the social environment included community access to and involvement in youth organizations or other extracurricular activities (Khanlou & Wray, 2014) and living in a close-knit community (Gewirtz & Edleson, 2007; Masten, 2007).

Research Tradition

The research tradition for the dissertation was phenomenology. Phenomenology originated in psychology and integrated a reflective interpretive process which was appropriate to this study (Moustakas, 1994). Creswell (2013) and Patton (2015) discussed several types of phenomenology. For example, hermeneutic phenomenology describes and interprets lived experiences as mediated by the researcher (Creswell, 2013). Heuristics phenomenology integrates the investigator's personal experiences and insights into the process of discovering intense human experiences (Patton, 2015). Lastly, transcendental phenomenology focuses on describing the experiences of the participants while the researcher brackets their experiences (Creswell, 2013). Commonalities across

all types of phenomenology are that they "…focus on exploring how human beings make sense of experience and transform experience into consciousness…" (Patton, 2015, p. 115).

My study integrated Moustakas (1994) research tradition of transcendental phenomenology. It's considered a philosophy as well as a method because it focuses on understanding the meaning, as described and experienced by the participants, to a phenomenon (Creswell, 2009; Rudestam & Newton, 2015). Moustakas's (1994) transcendental phenomenological approach is descriptive, rooted in psychology and integrates epoche as well as eidetic reduction (Creswell, 2013; van Maten, 2011). With this approach, I objectively used inductive qualitative methods such as observations which included non-verbal cues as well as body language and interviews to develop a deeper understanding of the participant's subjective experiences and set aside my experiences by bracketing and disclosing them (Creswell, 2013; Lester, 1999; van Maten, 2011). In my study, the phenomenon being examined is related to the resiliency, or lack thereof, of IPV-exposed children, aged 6-11 years, as perceived by their Puerto Rican mothers. I sought to fill a gap in the existing literature by examining the *"what"* and *"how"* of the mother's experiences using primarily interviews and holistically combining the data into themes using horizonalization to develop clusters of meaning (Creswell, 2013; Moustakas, 1994). All of the study participants were Puerto Rican mothers of children between the ages of 6 to 11 years who have been exposed to IPV so they would have experienced the phenomenon which is necessary for transcendental phenomenology (Creswell, 2013; Moustakas, 1994; Patton, 2015). The participant's answer's to the

broad, open-ended interview questions helped ensure that their collective experiences were captured during data collection, reduced and thematically analyzed (Creswell, 2013). The study contains both textural as well as structural descriptions which were combined into an essential, invariant structure which descriptively depicted the essence of their lived experiences (Creswell, 2013; Moustakas, 1994).

Summary and Conclusions

IPV is a complex phenomenon and the works I reviewed revealed that there were large gaps in the literature related to the Puerto Rican mother's lived experiences and their perceptions of how IPV impacted their IPV-exposed children. Some IPV exposed children exhibit less behavioral problems than others and this, as evidenced by the literature, has been attributed to their social supports (Holt-Lunstad & Uchino, 2015; Letourneau et al., 2013; Nouer et al., 2014) or their mothers decision-making (Kelly, 2009; Randell et al., 2012) or attitudes towards IPV (Kelly, 2009) but this isn't consistent across all children (Aymer, 2008; Milan & Wortel, 2015; Mogro-Wilson et al., 2013). It was unclear whether the cultural values of marianismo, familism, and respect were added stressors for the IPV-exposed children or whether they served as protective factors (Aysa-Lastra et al., 2012; Beauchamp et al., 2012).

Child exposure to IPV is a significant issue which impacts public health's ability to attain the overarching goal of ensuring the health and safety of society which is central to the broader ecological perspective of population health (Resnick & Siegel, 2013). Over the last few decades, researchers have started focusing on the resiliency of children and have moved away from deficit-oriented models. While much progress has been made in

exploring factors which promote child adaptation in the face of adverse events there were significant gaps that still need to be filled particularly with regards to Hispanic subgroups. The literature on child exposure to IPV is growing, but only a handful of studies have addressed child exposure to IPV among Hispanic subgroups (Aymer, 2008; Aysa-Lastra et al., 2012; Mogro-Wilson et al., 2013). The DHHS (2014) Healthy People 2020 includes objectives related to decreasing injuries and violence but there are cultural and societal factors which intersect with IPV that need to be explored (Bent-Goodley, 2008). The connection between health and IPV are clear in the literature but the analysis isn't complete when social and cultural factors have yet to be considered (Bent-Goodley, 2008). This issue influences public health's ability to meet its core functions (CDC, 2011) and the Healthy People 2020 objectives (DHHS, 2014).

Present Study

With this qualitative phenomenological study, I hoped to contribute to closing the gap in the knowledgebase identified in the literature. I explored how Puerto Rican mothers perceive exposure to IPV has impacted their children, aged 6 to 11 years, and the role of their unique cultural values and beliefs in this impact. Examining how Puerto Rican cultural values and attitudes impacted the IPV exposed child based on the Puerto Rican mother's perceptions was vital to gaining knowledge on their behavioral and social risks or protective factors, and to developing culturally appropriate interventions. The results of my study extended knowledge in the discipline by identifying how unique Puerto Rican cultural factors act as a risk or protective factors in IPV-exposed children as perceived by their Puerto Rican mothers. Public health personnel, healthcare providers,

law enforcement and other agency staff need to gain knowledge on this issue so that they can be empowered to take action towards changing social norms and to mobilize the resources needed to protect children from being exposed. Furthermore, the research could be used to enhance parental relationships with their children and to ensure that children have access to resiliency building resources including social support networks (Izaguirre & Cater, 2016). In Chapter 3 I will provide a detailed description of the methodology for this study.

Chapter 3: Research Method

Introduction

Purpose

There is a need for an increased understanding of Puerto Rican mothers' perceptions of how exposure to IPV affects their children to aid in the development of supportive, culturally- appropriate interventions. The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of mothers who are victims of intimate partner violence and their perceptions of how exposure to intimate partner violence may have impacted their children. The following sections of this chapter delineate the research design and rationale, the role of the researcher, the methodology, and issues of trustworthiness related to this study.

Research Design and Rationale

The research questions for the study are:

Research Question 1: What are the lived experiences of Puerto Rican mothers who are victims of IPV?

Research Question 2: What are the perceptions of Puerto Rican mothers who are victims of IPV on how exposure to IPV has influenced their children aged 6-11 years?

Sub-questions

- What knowledge do the Puerto Rican mothers have about their child's exposure to IPV?

- How do the Puerto Rican mothers describe the subcultural values of machismo, marianismo, respect, and familism in relation to IPV and subsequent child exposure to it?
- What is the meaning of adaptive coping for Puerto Rican mothers who have an IPV-exposed child?
- How do the Puerto Rican mothers describe the presence or lack of adaptive coping skills in their IPV-exposed child?
- How do they describe their parental relationship(s) with their IPV-exposed child?
- What social supports, role models or community resources do the Puerto Rican mothers believe have or have not supported their IPV-exposed child?

Central Concepts of the Study

The central phenomenon of this study was resilience. The central concepts of resilience for the IPV-exposed child, aged 6 -11 years, were defined as a healthy adaptive and developmental process which provides a child with the ability to overcome negative life or stressful events (Masten, 1994, 2014). It entails a combination of protective factors, despite exposure to adverse events, which can be viewed in terms of internal assets and external resources (Masten, 2007) at the individual, interpersonal and community levels (CDC, 2015b).

This study focused on the subjective perceptions of Puerto Rican mothers, with children aged 6-11 years on how exposure to IPV had affected their children. Through the use of a qualitative phenomenological research approach I explored the *"what"* and

"how" of the phenomenon by gathering rich-thick descriptions that captured the essence of these mothers' experiences as recommended by Creswell, 2013, Miles et al. (2014), and Moustakas (1994). The rationale for my choice of a qualitative phenomenological approach was that it was consistent with the research questions and the need to explore and understand the lived experiences of Puerto Rican mothers who had IPV-exposed children aged 6-11 years.

Role of the Researcher

The role of the researcher is a continuum which can range from being a silent non-participant observer to being a participant-observer but has many in-between variations (Creswell, 2013; Janesick, 2011; Patton, 2002). My role was comprised of being a researcher so that I could establish rapport, trust, and credibility with the participants (Creswell, 2013). This also allowed me to capture the selective perceptions and context of the interactions so that I remained open to discovery which enabled a holistic approach to inductive reasoning (Creswell, 2013; Patton, 2002). As a researcher, I was engaged in conducting the audiotaped interviews and interacting with the participants. The multiple and overlapping observations were conducted during the interviews but the documentation of observations during the interviews was kept to a minimal (Elliot & Timulak, 2005; Patton, 2002). At some point during the interview, I shifted my role to focus on the phenomenon but remained present to the participant (Englander, 2012). Changing the role of the researcher was essential to bracketing and maintaining objectivity (Chan, Fung, & Chien, 2013; Englander, 2012). The shift was

consistent with phenomenological research because my focus was on the phenomenon as described by the participant (Englander, 2012).

Past experiences with this community included having been raised there; however, it has been over 30 years since my family moved out of the neighborhood and I did not have a relationship with any of the participants. Therefore, to minimize possible power asymmetry (Creswell, 2013), I wore comfortable clothing and minimal jewelry because the participants were low-income Hispanic adults. Additionally, I offered them the opportunity to conduct the interviews in Spanish since I am bilingual and this may have been their preference. There was a possibility that the participants would view me as an outsider, but I made every attempt to promote equality during the interviews and involved them in the interpretation of the data (Creswell, 2013). Furthermore, I found that having olive skin and being Puerto Rican minimized some of the barriers.

Having been raised in a Puerto Rican household by first generation immigrants, the Puerto Rican values of *marianismo*, respect and family were instilled in me. Marianismo refers to the traditional female gender roles as family caretakers whereas *machismo* refers to the traditional masculine role as the provider and protector of the family (Galanti, 2003; Mogro-Wilson, 2013). My father was a hardworking man and my mother was responsible for running the household and raising me and my siblings. As a child, alcohol played a role in my having witnessed IPV perpetrated by my father towards my mother. As a nurse, I realized that alcoholism is a disease so I have accepted his shortcomings. As a child, I also witnessed IPV among the parents of some of my friends but the topic was never discussed. In contrast, my grandfather was a kind, honorable,

respectful, hardworking man who adored my grandmother, his children, and grandkids. I never witnessed him raising his voice or being disruptive to anyone. Thus, from a cultural perspective, the concept of machismo, varied among my most important male role models when I was a child.

As a professional woman, I developed a modern day view of machismo which includes shared decision making, equality, open communication, and mutual respect (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006). However, my personal biases, as a result of my upbringing and experiences were bracketed (Moustakas, 1994). I engaged in reflexive journaling, accepted participants who meet the predefined criteria, remained objective to the phenomenon as described by the participants, and did not offer or provide them with any personal opinions or advice (Creswell, 2013). My dialogue with the participants was transparent, compassionate, empathetic, and non-biased. Lastly, the prospective participants lived in an underprivileged community, and refraining from stereotypes and labels was essential to gaining their trust (Creswell, 2013). Entry to the sites were gained through professional networks (Creswell, 2009) who primarily posted the English (Appendix I) and Spanish (Appendix J) flyers. Thus, personal biases, as a result of my background, did not interfere with data collection or data analysis processes (Creswell, 2009; Laureate Education, Inc., 2009).

Other Ethical Issues

The sensitivity of the topic combined with the victimization of the participants made this a hard to reach population (Namageyo-Funa et al., 2014). Additionally, several research studies have shown that the values of familism, marianismo and respect may

merit that problems such as IPV remain within the family (Dietrich & Schuett, 2013; Galanti, 2003; Mogro-Wilson, 2013). It's also important to note that Ahrens et al. (2010) found that cultural taboos, shame, and embarrassment may inhibit IPV disclosure among Hispanics though this issue varied by country of origin among their participants. Nonetheless, as a token of appreciation, a $10.00 Target gift card, was provided to the participants at the beginning of the first interview and a $10.00 Target gift card was provided to each of the participants as a way of respectfully thanking them for their time at the beginning of the second interview, regardless of whether they decided to do the entire interview or not, and was disclosed on the consent form. The token of appreciation was announced in the flyers (Appendix I & J).

Methodology

Population

My study took place at a local community organization or another location as preferred by the participants. The target community was in the South Bronx area which is one of the poorest boroughs of New York City (CCC, 2015). The South Bronx community is a racially and ethnically diverse minority population of 56, 678 (per square mile) primarily Hispanic (72%) and Black/African American (25%) individuals (U. S. Census Bureau, 2010). The target population for recruitment were adult mothers, over 18 years of age, who were victims of IPV (USPSTF, 2013), and had one or more Puerto Rican primary school-age children between the ages of 6 to 11 years who were exposed to IPV.

A DOHMH (2008) report on IPV found that the South Bronx had the highest rates of femicide's, IPV-related hospitalizations, and emergency room visits in New York City. IPV-related hospitalizations were three times greater for pregnant than non-pregnant women, but data was lacking on the number of children exposed (DOHMH, 2008). However, South Bronx femicide police reports found that nine percent had IPV-exposed children and almost 40% had children living in the home at the time of the fatality (Fernandez-Lanier & Gilmer, 2008; New York City Domestic Violence Fatality Review Committee, 2014). Lastly, the district accounts for about one-third of the city's domestic violence reports (New York City Mayor's Office to Combat Domestic Violence [OCDV], 2014). Local, state, regional and national demographics are shown in Table 1.

Table 1.

Local, State, Regional and National IPV Risk Factor Demographic Data

	Local	New York State	Northeast Region	National
% population ≤ 18 years of age	35%[1,2]	24%[6]	22%[6]	22%[6]
Median household income	$27,340[1,2]	$54,659[3]	$56,775[3]	$51,939[3]
% ≥ 25 years of age with a high school diploma	23%[4]	28%[3]	25%[5]	25%[4]
Single Female headed households	22%[1,2]	15%[5]	13%[5]	13%[5]
With own children ≤ 18 years of age	29%[7]	7.5%[6]	7%[5]	7%[5]

Sources:
City-data.com, 2011[1]
CLRChoice, Inc., 2012[2]
DeNavas-Walt & Proctor, 2014[3]
DHMH, 2008; Ryan & Siebens, 2012[4]
Howden & Meyer, 2011[5]
Lofquist, Lugaila, O'Connell, & Feliz, 2012[6]
U. S. Census Bureau, 2010[7]

Table 1 shows the local area has a large population of children, a low median household income, low levels of educational attainment, and a large number of single female-headed households with children as compared to other regions. These demographics are consistent with many IPV risk factors (WHO, n.d.).

Sampling Strategy

I used a purposive non-probability criterion sampling strategy (RWJF, 2008) to elicit in-depth information from a smaller number of cases (Patton, 2015). Purposive sampling strategies are frequently used in qualitative research because the selection of the participants is based on the study's approach, research problem and phenomenon (Creswell, 2013). Additionally, in a non-probability sample inclusion is restricted which limits its representativeness to the general population (Frankfort-Nachmias & Nachmias, 2008) but, was appropriate to describing the experiences of the participants in my study. I used a Spanish or English tool (Appendix H) to screen all potential participants telephonically to ensure that they met the predetermined criteria. I also made myself available should potential participants have questions or want to meet in person and, being bilingual, was be able to screen and converse with them in their preferred language. Having a variety of strategies for recruiting and screening participants aided in obtaining individuals who meet the sampling criteria.

Criteria

My purposive sample was based on:

- a Puerto Rican mother, over aged 18;

- a victim of intimate partner violence;
- had a 6-11 year old IPV-exposed child;
- agreed to participate in two audio-taped interviews.

The criterion sampling strategy aided in attaining information rich cases (Patton, 1990), provided focus, and assisted in setting boundaries so that the most appropriate participants were defined (Miles et al., 2015) based on the phenomenon, research questions, theoretical framework, time, and resources (Creswell, 2013; Maxwell, 2005; RWJF, 2008). To establish that the participants were known to meet the sampling criteria, I screened them by asking them questions related to their background and experiences (Englander, 2012) using a tool (Appendix H).

Sample Size

My phenomenological qualitative research study consisted of multiple cases of participants which added confidence, validity, case generalizability, and credibility to the findings and were to be composed of a sample size of about 15 participants (Miles et al., 2014). Miles et al. (2014), Dukes (1984) and Creswell (2013) recommended that sample sizes for phenomenological studies should generally not be larger than 10 participants to ensure the collection of rich-thick data. However, the proposed sample size for the dissertation was 15 participants because this number of participants would have provided manageable opportunities for real-world inquiries using a holistic perspective which focused on depth and credibility (Maxwell, 2005; Patton, 2015). However, since saturation was achieved prior to collecting data from the proposed 15 participants, I

consulted with my committee to determine whether the additional data should be collected.

Saturation and sample size. In qualitative studies, the principle of saturation (Miles et al., 2014; O'Reilly & Parker, 2012) is used as a driver to estimate the quality of the data collected and is often utilized to establish the sample size based on research criteria (Tay, 2014). Thus, data saturation is a measure of qualitative data content validity (Francis et al., 2010; Miles et al., 2014). Therefore, I determined the actual sample size by the criteria of saturation or data that encompasses rich, thick descriptions which occurred when the themes or concepts identified became redundant, and no new findings were evident (Miles et al., 2014; Tay, 2014). The use of saturation as the primary determinant of the actual sample size helped me ensure that the experiences of the participants were captured as the research emerges (Mason, 2010; Miles et al., 2014). However, the degree of saturation was highly dependent on the quality of the data to support the findings (Francis et al., 2010; Miles et al., 2014; Tay, 2014). Thus, my use of interview questions designed to obtain rich-thick descriptions of the lived experiences of the participants was vital and ensured through the use of open-ended questions (Creswell, 2013; Miles et al., 2014).

Search Procedures

My identified participant recruitment efforts were based on the use of multiple strategies including developing trusting and mutually respectful relationships (Creswell, 2013). For example, I included information sessions with adult male and female well known respected gatekeepers who lived in the community, distributed of flyers

(Appendix I & J) at multiple neighborhood sites, and had various sources speak to propective participants about the study and distribute flyers (Namageyo-Funa et al., 2014). Potential referrals were coordinated through community health care providers, domestic violence organizations, and other community resources as well as neighborhood organizations (Creswell, 2013). I held several informational bilingual education sessions with potential referral sources, including gatekeepers, to enable the identification of potential participants who may have met the criteria. Prospective participants all contacted me directly via telephone for the initial screening. Once I had screened them, and determined that they met the criteria and were willing to provide consent to participate, an interview time and date was arranged in a secure, comfortable and private location at the community or another location based on their preferences.

Instrumentation

Two data collection instruments were used. The first consisted of a semi-structured interview protocol in English (Appendix A) and Spanish (Appendix B), based on the participant's language preference, as a procedural guide to collect data. The interview protocol aided in organizing the procedures and provided a place for documenting responses to the questions which I used to track and analyze the data (Creswell, 2013). I also used the protocol to add cues or reminders of points I covered in the beginning and at the end of the interviews (Creswell, 2013; Jacob, 2012). I audiotaped the interviews, with the participant's consent, downloaded them into my password-protected computer, transcribe them verbatim into a Word document and imported them into NVivo.

Additionally, I also used an observation sheet (Appendix G) to record descriptive and in-depth reflective field notes (Creswell, 2013). It was used to document very brief notes during the interviews, based on my role as a researcher, and to formulate more detailed notes immediately following the interviews once the participant had left as part of my debriefing process (Creswell, 2013).

My use of interview and observation protocols provided focus and structure to the data collection and analysis process (Creswell, 2013). Lastly, the participants were asked to bring readily available data including, but not limited to, school progress reports or other pertinent sources (Creswell, 2013) but none of them did.

Sufficiency of data collection instruments. The self-developed unpublished semi-structured interview protocol (Appendix A & Appendix B) followed open-ended interview question as recommended by Creswell (2013), Maxwell (2005), Miles and Huberman (1994), Miles et al. (2014), and Patton (2015). The questions were formulated based on the premise that the interview was a collaborative interaction and were designed to evoke a detailed account of the lived experiences of the participants (Patton, 2015). The primary and secondary research questions provided the basis for the interview questions, which were formulated based on the participants' levels of literacy and the situation (Maxwell, 2005). I began the interviews with an introduction of myself, the research, procedures to assure confidentiality, review of consents, and the collection of necessary background information which aided in establishing trust and rapport (Creswell, 2009). Once rapport had been established I started with an ice breaker and

proceeded with questions in a hierarchal manner from least to more intimate (Jacob, 2012).

Additionally, the observation sheet or protocol (Appendix G) was a replica, which I created, of the sample observation protocol designed by Creswell (2013). It consisted of a column for descriptive notes and a column for reflective notes (p. 169) which met my needs for recording observations.

Researcher-developed instruments. The interview protocol's content validity was established by an outside panel of experts in the field of domestic violence using an Expert Panel Review Protocol (Appendix K). Once it had been reviewed and approved by my committee I electronically submitted it for input from the expert panel. Three individuals were chosen to review the content including the tone, wording and topic alignment of the questions as they related to the phenomenon (Frankfort-Nachmias & Nachmias, 2008). Consensus, as judged by the expert panel, that the interview protocol captured the elements of resilience, or the lack thereof, among children as perceived by their mothers, reinforced the content validity of the semi-structured interview protocol.

Procedures for Pilot Study

I conducted a pilot study with IRB approval. The reason for the pilot study was to test and refine the semi-structured interview protocol prior to the main study. Additionally, the pilot study was also an opportunity to advance the proficiency of my interviewing and observation techniques. Furthermore, it provided me with opportunities to identify any design flaws and make corrections before the main study was implemented (Turner, 2010). Recruitment procedures for the pilot study entailed my

distributing flyers (Appendix I & J) for potential participants in the target community at local domestic violence and community organizations. The pilot study participants were excluded from my main study. The flyers had my contact information. Potential participants were screened (see Appendix H) by me to ensure that they were a representative sample based on the criterion sampling strategies used for the main study. If they met the criteria and agreed to participate, interviews were arranged, and data was collected using the approved and content validated semi-structured interview protocol with IRB approval 02-20-170118883 which expires on February 19, 2018.

Procedures for Recruitment, Participation, and Data Collection

I collected self-reflective data in the form of journaling to assist with bracketing (Creswell, 2013; Janesick, 2011; Patton, 2015). Here I documented regular self-reflections of my attitudes and feelings which was vital to reducing bias (Janesick, 2011). My observations were also documented, on the observation sheet (Appendix G).

Prior to initiating the interview, I asked the participant about their language preference and had two copies of the English (Appendix D) and Spanish (Appendix E) informed consent documents available. I informed each of the participants that their participation was voluntary, that the interview(s) would be audiotaped and that they could withdraw at any time and still receive the thank you gift of a $10.00 Target gift card at the beginning of the first interview and a $10.00 Target gift card at the beginning of the second interview. The participants were informed that the initial interview would last about 90 minutes and the allotted timeframe was respected. They were also made aware that there would be a follow-up interview which would last no longer than one hour

within two weeks and that I would contact them to arrange it (Creswell, 2013). I reviewed that the research study was on their child's exposure to IPV and explained that I was conducting it because there was minimal information on how exposure to IPV may impact children aged 6-11 years, as perceived by Puerto Rican mothers. I reviewed the individual risks associated with discussing the sensitive topic including emotional discomfort or shame and how the study could benefit the community by enhancing disclosure among mothers as a result of informing health care providers on culturally appropriate ways to address the subject so that families could receive early interventions. I informed them that I, as a professional Registered Nurse, I was a mandatory reporter and the procedures that would be taken if child abuse or neglect was suspected. I also informed them that they could chose not to answer a question if they felt emotionally uncomfortable, reschedule the interview and that the consent form included a list of free resources in the community should they need to talk with someone regarding their situation or feel distressed after the interview. Additionally, I discussed that in the event that the interview is interrupted, I would stop talking. I also explained the procedures that I had in place for ensuring their privacy and confidentiality including the assignment of a unique code; a separately stored legend that only I would have access to in my password-protected computer; that the data would be stored in a locked file cabinet for five years; and that any details which may identify them or the location of the study would not be shared. At this point, I reviewed the entire consent form verbally, had the participant read it and provided them with an opportunity to ask any questions prior to obtaining their signature. The interviews were primarily conducted at a local community organization

where I would have secured private office space in advance or at another location based on their preference.

Interviews were audiotaped with a portable digital voice recorder which was downloadable into the computer, had a long battery life, a plug-in option, large storage capacity, and recorded in MP3 format which was compatible with NVivo 11 Plus. Recording the interviews was essential to managing the data and summarizing it (Soriano, 2013; Vilela, 2012). Also, as a back-up, I recorded the interviews on my iPhone using an app. The follow-up plan if the recruitment process resulted in too few participants would have been to contact local churches, health care providers, and community youth groups and educate them about the research project as well as confidentiality procedures and the social change impact the research could have for the community.

Participant Exit Procedures

I debriefed each of the participants before they exited the interviews. I thanked them for their participation, and their courage, explained the purpose of the study again, and politely asked them not to discuss the study with anyone they might think may be eligible to participate. I explained that their cooperation with not discussing the study would be greatly appreciated because it may invalidate the final results. Additionally, I reviewed the resources listed on their signed copy of the consent form, should they experience any distress after participating and my contact information. I also reminded them that I would contact them to confirm the scheduled second interview and we discussed how this could best be accomplished. I informed them that, at the beginning of

the initial interview, they would be provided with the $10.00 Target gift card and a $10.00 Target gift card at the beginning of the second interview as a token of appreciation regardless of whether they decided to participate in the entire interviews or not, or stop once the interview had started. Based on the preferences of the participants, I arranged to provide them with a written summary of the interview for member-checking in-person or by email, at some future time and they were asked to provide their input including any changes or additions.

Data Analysis Plan

Data analysis followed the procedures used in transcendental phenomenology (Moustakas, 1994) and was based on the research questions. I initiated data analysis techniques, using constant comparison, during the data collection phase (Creswell, 2013; Patton, 2015). I read and summarized the interview, observational and reflective notes into a concise contact summary form (Miles et al., 2014). The form was a one-page document with questions, answered by me within a few days after the contact, which provided focus and opportunities to reflect on the written and corrected field notes (Creswell, 2013; Miles et al., 2014). The aggregation process formed a preliminary interpretation which was used to code data into themes (Creswell, 2013). I also used the contact summary form as a planning tool to guide the research process (Miles et al., 2014).

I read the individual interviews several times, transcribed each of them onto a case dynamics matrix (which aided in determining preliminary explanations based on the research questions) (Miles et al., 2014), transcribed them verbatim into a Word document

and imported the document into NVivo 11 Plus qualitative data analysis software program (QDAS) (Creswell, 2013; Harrell & Bradley, 2009; Rudestam & Newton, 2015; QSR International, n.d.). Additionally, I also downloaded the audio-taped interviews into NVivo and audited them. Follow-up interviews were conducted as scheduled, audiotaped, read, transcribed verbatim, audited, and imported into NVivo. The interview and observational data was organized into broad, meaningful clusters of how the participants were experiencing the phenomenon for open coding (Creswell, 2013; Miles et al., 2014; Miles & Huberman, 1994; Saldaña, 2016). Reflective notes and memos were added; the data was reduced and coded (Rudestam & Newton, 2015). Coding was descriptive, category based and analytical which allowed for the creation of new categories (Rudestam & Newton, 2015). The coded clusters were further evaluated, reduced to a series of significant statements, then grouped into meaning units and themes (Creswell, 2013; Miles et al., 2014; Miles & Huberman, 1994). In this way, distinctive textural and structural themes were derived from the participants' experiences as a whole to capture the essence of the experiences of the group (Moustakas, 1994). These strategies were consistent with transcendental phenomenological approaches, the research questions, the data collected, and emphasized what was conceptualized about the study (Creswell, 2013; Miles et al., 2014; Miles & Huberman, 1994). Thus, both content and thematic analysis procedures were used throughout the data analysis phase (Patton, 2015). Discrepant cases were further analyzed and disclosed in the final write-up (Miles et al., 2014; Patton, 2015).

Software. I used NVivo 11 Plus QDAS to download the audio-recorded data, adding attachments, analytic memoing, and as an internal process for tracking data changes (Bazeley & Jackson, 2013; Creswell, 2013; Miles et al., 2014). Thus, NVivo was used to organize, document and track the research process including data collection and analysis (Creswell, 2013). The software program enhanced my ability to link, code and construct data categories, perform a content analysis and draw conclusions (Creswell, 2013; Miles et al., 2014). NVivo also provided me with a higher level of structure and organization than the case matrix alone (Creswell, 2013; Patton, 2015). NVivo has multiple built-in queries and reports which were useful for analyzing the data in different ways and were also used to build visual models (Bazeley & Jackson, 2013; Creswell, 2013). Also, the use of a case-matrix, as well as NVivo, provided inductive and logical opportunities for me to explore outliers, identify follow up surprises, assess competing explanations, and make if-then tests which enhanced credibility (Miles & Huberman, 1994; Patton, 2015).

Issues of Trustworthiness

Credibility

I engaged in self-reflection through journaling as a bracketing procedure to reduce biases or presuppositions and enhance objectivity before data collection (Creswell, 2013; Maxwell, 2005; Miles et al., 2014). I established credibility through the use of multiple sources of data or triangulation which included my documented and transcribed observations of the participant's non-verbal cues and body language, the audiotaped interviews, and the interview protocol notes (Maxwell, 2005). Furthermore, I accessed

and utilized the documentation from the contact summary form, case dynamics matrix, reflective notes, memos and the information transcribed into NVivo. I attained consensual validation which involved making judgments about what was meaningful and substantively significant in the data based on the reports of the participants (Patton, 2015). Consensual validation through member checking, at various stages of the research process, also aided in establishing credibility and allowed the participants an opportunity to provide their feedback by confirming or disconfirming the accuracy of the analysis (Creswell, 2013; Maxwell, 2005; Patton, 2015). Member checking was conducted by providing each of the participants with a transcribed document of their data for their feedback. Member checking also gave the participants a voice, was consistent with a participatory perspective (Kelly, 2010; Patton, 2015), and provided a reciprocal process in the relationship between the researcher and the participant (Creswell, 2013). Lastly, records were kept of any alternative explanations and examined during data analysis to ensure credibility (Patton, 2002).

Transferability

In addition to the strategies for establishing credibility, I included transferability strategies such as interview questions which triggered episodic memories rather than abstract generalizations (Weiss, as cited in Maxwell, 2005; Patton, 2015). The Spanish and English interview protocols (Appendix A & Appendix B) were comprised of carefully considered open-ended questions which allowed for rich, thick descriptions (Creswell, 2013; Miles & Huberman, 1994; Miles et al., 2014; Patton, 2015). My description of the findings using rich-thick descriptions allowed readers to determine

their potential transferability in other settings (Miles et al., 1994; Patton, 2015). I also provided a full description of the de-identified participants, setting and processes used which also permitted comparability to other samples (Miles & Huberman, 1994). Lastly, my integration of triangulating data using multiple sources, written evidence and creating a case matrix where the text is compared and contrasted was utilized as a strategy for transferability (Miles & Huberman, 1994; Miles et al., 2014; Patton, 2015).

Dependability

Additionally, I established dependability by using an audit trail through NVivo (Bazeley & Jackson, 2013; Gentium Consulting, n.d.; Patton, 2002). The software has a built-in audit trail which was vital to cross comparisons and member checking (Bazeley & Jackson, 2013). The documentation provided a complete record of the processes and decisions made which can be reviewed by others. Also, a clear description of the studies design and how it was implemented was also a strategy that I used to establish dependability (Shenton, 2004). Lastly, I also employed triangulation through the collection of multiple forms of data for dependability.

Confirmability

Lastly, I also integrated some confirmability strategies to aid in ensuring trustworthiness. The procedures were designed to ensure that the findings represent the experiences of the participants and were not based on my preferences or own ideas (Shenton, 2004). Thus, similar to dependability, I integrated audit trails and triangulation to ensure confirmability (Shenton, 2004). Additionally, I used a strategy of reflexivity. The characteristic of reflexivity entailed that the researcher "position themselves" in the

study and journaling can form the basis as to how my personal story is communicated to the participants (Creswell, 2013, p. 47; Janesick, 2012; Ortlipp, 2008). I used journaling to assist with clarifying the research design, approach, and the overall progress of the research because it's an educational, motivational and interactive tool (Janesick, 2012). Also, it was integrated into the study and used to enhance my understanding of the participant responses (Janesick, 2012). Engaging in reflexivity by keeping a journal to document the analytic process also provided a foundation for rigor while I was involved in data analysis and helped me identify potential design changes that may have needed to be made (Patton, 2015).

Intercoder Reliability

The strategies for reviewing the quality as well as the accuracy of data collection processes and analysis included triangulating analysts to aid in ensuring quality and reliability (Creswell, 2013; Miles & Huberman, 1994; Patton, 2015). Intercoder agreement checks of the transcripts through independent coding (Creswell, 2013) were used by me to test reliability (Miles & Huberman, 1994) and performed by a research assistant. My use of a research assistant who independently coded and analyzed the data enhanced the internal and external validity of the findings. My goal was to attain a minimum of a .80 (80%) intercoder coefficient agreement for thematic analysis (Miles & Huberman, 1994; Mouter & Vonk Noordegraaf, 2012).

Independent coding process. Independent coding entailed a series of steps to ensure that the procedures were valid and reliable (Creswell, 2013; Patton, 2015). The process entailed that I independently code all of the interview transcripts and have the

research assistant independently code the same transcripts using NVivo (Creswell, 2013). Once the research assistant had coded the transcripts, we compared our notes to assess if we agreed on the actual coding and determined whether the coding was appropriate or should be revised based on our discussions (Miles & Huberman, 1994). I would do this via webinar if the research assistant was not in my home city, or would meet with the research assistant to debrief in person and achieve agreement. The codes were compared and we also evaluated the consistency of the codes assigned to the text segments (Creswell, 2013). The reliability or concordance was determined using a comparison coding query in NVivo which divided the number of agreements by the total number of agreements and disagreements (Miles & Huberman, 1994). I developed a concept map of the codes (Miles & Huberman, 1994) to create the initial buckets using broad themes and the same independent coding processes for all of the interview transcripts, was used for thematic intercoder agreement (Creswell, 2013). This allowed me to assess if the research assistant and I used the same themes to code passages, collaboratively discuss needed revisions, and enabled us to reach a consensus prior to my revising the codebook (Creswell, 2013). Additionally, I used memoing as well as if-then tests in the field during data collection to determine the consistency or lack thereof, of identified pattern codes (Miles & Huberman, 1994).

Measures to Address Limitations

I was responsible for evaluating that the participants met the predefined sampling criteria. The sample size of 15 was consistent with the literature for phenomenological research (Creswell, 2013; Dukes, 1984; Miles et al., 2014) but the final number of

participants was based on the principle of saturation (Miles et al., 2014; O'Reilly & Parker, 2012) and consultation with my committee members. Furthermore, my use of a purposive non-probability criterion sampling strategy was consistent with qualitative phenomenological approaches (Miles et al., 2014; Moustakas, 1994) but I was solely responsible for screening the participants to ensure that they met the criteria. Bracketing was integrated, and interview techniques focused on questions which triggered episodic memories rather than abstract generalizations to reduce potential biases (Weiss, as cited in Maxwell, 2005; Moustakas, 1994; Patton, 2015). Additionally, the use of multiple sources of data or triangulation reduced biases and enhanced credibility (Maxwell, 2005). Thus, I strived to attain consensual validation which involved making judgments about what was meaningful and substantively significant in the data based on the reports of the participants and the receptivity of the consumers of the research products (Patton, 2015). Lastly, I used member checking, as a test, to establish credibility so the participants had an opportunity to provide their feedback by reviewing the preliminary content analysis and confirm or disconfirm the accuracy of the analysis (Creswell, 2013; Maxwell, 2005; Patton, 2015). Dependability was also established through an audit trail in NVivo, data triangulation and a description of the design as well as how it was actualized (Shenton, 2004). Lastly, potential threats to quality related to the accuracy of data collection and analysis procedures were minimized (Miles & Huberman, 1994). The strategies for reviewing the accuracy of data collection processes and analysis included triangulating analysts which aided in ensuring quality and interrater reliability (Creswell, 2013; Miles & Huberman, 1994; Patton, 2015). Additionally, intercoder agreement checks of the

transcripts through independent coding (Creswell, 2013) was used to test reliability (Miles & Huberman, 1994). Lastly, in addition to validity and reliability, phenomenology approach specific standards were utilized to evaluate quality (Creswell, 2013; Miles et al., 2014).

Ethical Procedures

I initiated the process of building relationships with domestic violence and community organizations early on. The domestic violence and community organizations responsibilities were to post the flyers for the recruitment of potential participants. The domestic violence and community organizations who posted flyers at their locations didn't conduct any research at their sites and didn't have an IRB (J. Jenkins, personal communication, October 26, 2016) but letters of cooperation (Appendix C) were obtained since the IRB required them. I did not access any data from the organizations on any of the services they provided to the participants. The initial screening and interview date arrangements were made telephonically by me. However, if any of the potential participants preferred to meet in person for the screening, then I would have coordinated with them to make arrangements to meet at a location of their choice but this wasn't necessary. All data collection activities occurred in a convenient, comfortable, safe, and private place or another private location as preferred by the participant. The organization who provided me with the private office space also signed a letter of cooperation (Appendix C). They don't conduct any research at their site and don't have an IRB (D. Diaz, personal communication, October 18, 2016). Additionally, I treated each of the participants with the utmost respect and dignity and they were required to sign a study

tailored informed consent form in English (Appendix D) or Spanish (Appendix E). Full disclosure and transparency was essential to obtaining informed consent and to participant involvement (Creswell, 2013). Informed consent documentation detailed the participant's right to withdraw, the benefits and risks involved, my mandatory reporting responsibilities, the purpose of the study, data collection procedures including interviews and audio-taping, and how their confidentiality would be protected (Creswell, 2013; National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Additionally, since the interview process may have stirred up negative emotions, and I reviewed and provided them with information on free and local referral sources on the consent form (Creswell, 2013; WHO, 2003). However, I understood that though resources were made available it was ultimately the participant who decided whether or not to use any interventions (WHO, 2003). Lastly, the research assistant, who was utilized for the intercoder agreement checks, signed a confidentiality agreement (Appendix F), as required by the Walden University IRB, before accessing de-identified confidential participant data.

Recruitment Materials and Process Concerns

One ethical concern related to the safety of the participants (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979; WHO, 2003). The WHO (2003) recommends that recruitment materials should focus on the health of the participants and their life experiences. However, since my study focused on the health of children as perceived by the mothers, the flyer (Appendix I & J) specified that the study was on the family relation experiences of Puerto Rican mothers

who have children aged six-11 years who have been exposed to intimate partner disturbances. While this may have been broad, participant screening procedures and consents provided more specific details of the study (WHO, 2003) and a member of the Walden University IRB was in agreement with the wording of the flyer (IRB Member, personal communication, October 24, 2016). The recruiting procedures were designed to decrease the risks associated with potential perpetrator retaliation and provided the participant with an explanation which could have been given to individuals who may have inquired about the study (WHO, 2003).

There was a potential that some of the participants would choose a different location for the interviews other than the organization where a private office could be used. Additionally, some of the participants may have preferred to meet in the evenings which presented safety issues for me. In such cases, I would have had an escort accompany me to the location and wait for me in the car (WHO, 2003). Furthermore, in situations where the interview might have been interrupted by another individual, the participant was forewarned that I would stop talking until privacy was assured. If privacy wasn't assured during the interview, the participant and I would address the need to possibly reschedule the interview on a day, time and location that was convenient to them or move to another location.

Lastly, under-reporting may have been a challenge in this study due to the topic and the cultural values of the participants (Ahrens et al., 2010; Beauchamp et al., 2012; Kelly, 2009). The wording of the semi-structured interview questions focused on acts (hitting, slapping, yelling, etc.) and the scope of the behaviors across various settings

(WHO, 2003). I had also taken an online continuing education course which provided some excellent techniques used by law enforcement and CPS workers for interviewing IPV victims (Coleman & Howlett, 2011). Furthermore, I planned on conducting the interviews alone and being a middle-aged female of the same culture enhanced disclosure (WHO, 2003). Additionally, I had procedures in place where experts, who work with various cultures in the target community, assessed the content validity of the semi-structured interview protocol and my having piloted it had a positive influence on disclosure (WHO, 2003).

Ethical data collection concerns. One data collection concern related to obtaining IRB approval for the study. The study focused on a sensitive topic as well as a vulnerable population (DOHMH, 2008) which were considered red flag issues (Walden University, 2016) and would likely have remitted a full review by the IRB before I obtained their approval (Creswell, 2013). I had consulted with the IRB, and they confirmed that ensuring that I covered all aspects of the study in the application and consent would help expedite their review (Walden University, 2016). Another data collection concern related to the potential for participants to withdraw early from the study by not participating in the second interview. In such cases, I made at least three attempts to contact them and reiterated the confidentiality procedures, my availability based on their schedule and how their contributions to the study would impact the community. Additionally, building trusting and mutually respectful non-judgmental relationships early on also enhanced their continued participation (Creswell, 2013).

Another data collection concern was related to participation. Before initiating the interview, I reviewed the consent form, answered any questions and obtained a signature from the participant's (Creswell, 2013). The participants were also informed that the data collected would be de-identified using a unique code and that the audiotapes would be securely stored and erased after five years (WHO, 2003). The follow-up interviews were scheduled based on the participant's availability, at a safe location which was convenient to them and entailed obtaining a verbal agreement that they're still voluntarily willing to participate in the study (Creswell, 2013).

Lastly, there was a possibility that the interviews would stir up negative emotions and providing the participants with time to collect themselves, being empathetic and actively listening was vital. However, if the participant experienced high levels of distress, I would have inquired about terminating the interview, rescheduling it and would reinforce the mother's strengths, courage, the resources available to her, and how her contribution to the study would be utilized to help IPV-exposed children and the community. Most importantly, I would identify the immediately available, free, bilingual, local counseling resources, which were delineated on the consent form and several toll-free hotlines.

Data Treatment

I was the only one with access to the names of the participants and their confidential information (Creswell, 2013). All of the data collected was de-identified; each participant was assigned a unique code and the coding legend was kept in a password secured computer which only I could access (Creswell, 2013). Additionally,

hard copies of data including original documents are being stored in a locked cabinet in my private home office for five years. The audio-taped interviews were downloaded and transcribed into NVivo and will be stored for five years in a locked cabinet in my home office. Also, electronic files will be stored and backed up in a secure password-protected online database which only I can access. An electronic master list and a visual data collection matrix was developed, stored on my password protected computer, and used to locate study information (Creswell, 2013) but does not contain identifying information. Lastly, the de-identified data was shared with the research assistant for intercoder reliability purposes, but no access to the coding legend was provided. Furthermore, the findings were disseminated in a de-identified format that will not reveal the identification of the participant's or the particular community (WHO, 2003).

Other Issues

The sensitivity of the topic required me to discuss safety and security concerns with the site where data collection will take place (WHO, 2003). Also, the neighborhood where the data collection will be held is a high crime area so precautions were also taken to ensure my protection. The private office space was located in the neighborhood and was the preferred choice for meeting with the participants. The locations had knowledge that I would be coming because a private room was pre-arranged. I updated the central contact person at the location with my husband's contact information and asked them to call him if I don't show up for a planned appointment. If the plan or location changed they were notified by me in advance. Additionally, I also alerted the gatekeepers in the community of the date, time and general locations of the meetings but did not divulge

with whom I was meeting if any of the participants choose to be interviewed in their home. I deterred from meeting individuals in their homes whenever possible particularly since I have set up private office space in locations they can easily access. Additional precautions I took included conducting interviews during the day when possible, texting my spouse when I got to my location and left, and dressed down so that I didn't stand out. Lastly, at the beginning of the first interview the participants were provided with the $10.00 Target gift card as a token of appreciation and a $10.00 Target gift card was provided at the beginning of the second interview as disclosed on the flyer (Appendix I & J) and on the informed consent (Appendix D & E).

Summary

The qualitative research design for this study provided opportunities to explore the phenomenon holistically and provided the best fit based on the purpose and research questions. The utilization of Moustakas (1994) transcendental phenomenological approach aided in ensuring that the essence of the subjective lived experiences of the mothers were captured, and that researcher bias was minimized through bracketing. Furthermore, it provided a comprehensive structure for collecting and analyzing the data. My role as a researcher was to develop relationships with the participants and to use a back and forth process which entailed focusing on the phenomenon (Englander, 2012).

I had no prior existing relationships with any of the participants and took various steps to minimize or eliminate any power differentials as well as researcher bias. The participants were recruited from a community which has been identified as being at high risk for IPV and has a large population of Hispanic subgroups and young children

(DOHMH, 2008). It was a high-crime community and I had several measures in place to protect my safety. A $10.00 Target gift card was provided to each of the participants as a token of appreciation at the beginning of first interview, regardless of whether it was completed or not, because this was a hard to reach population whose subcultural values may have influenced IPV disclosure. Additionally, a $10.00 Target gift card was provided at the beginning of the second interview. Both the $10.00 Target gift cards were disclosed on the flyer (Appendix I & J) and the consent form (Appendix D & E). To gather rich-thick descriptions, a non-purposive criterion sampling strategy was predetermined, and the participants contacted me for the initial screening. A sample size of 15 participants was initially recommended but the actual sample size was determined based on the principle of saturation and communication with my committee members.

I planned to collect data for the pilot and main study at a local community organization or the Mott Haven public library which were private and safe locations. The data I collected consisted of observations related to the participant's non-verbal cues and body language and two audio-taped interviews using a content validated semi-structured interview protocol. I identified various strategies to address issues of trustworthiness including credibility, transferability, dependability, confirmability, and intercoder reliability. Furthermore, I initiated discussions with potential referral sources whose role would comprise of posting flyers at their respective locations and providing private office space. IRB requirements included a Letter of Cooperation from community partners, I also attained Letters of Cooperation from the sites where flyers were posted or office space was provided, a participant consent form in English and Spanish, and a

confidentiality agreement for the research assistant. Furthermore, I consulted with the IRB for recruitment advice which included the wording of the flyer, potential issues related to the sensitivity of the topic and the vulnerability of the population. Lastly, I built in checks and balances that ensured that the treatment of the data protects the confidentiality of the participants and are in accordance with ethical guidelines. In Chapter four I will provide a detailed description of the pilot study findings.

Chapter 4: Results

Introduction

There is a need for an increased understanding of the Puerto Rican mothers' perceptions of how exposure to IPV affects their children aged 6-11 years to aid in the provision of supportive culturally appropriate interventions. The purpose of this qualitative phenomenological study is to explore and understand the lived experiences of Puerto Rican mothers who are victims of IPV and their perceptions of how exposure to IPV may have influenced their children. The two research questions were (a) What are the lived experiences of Puerto Rican mothers who are victims of IPV? and (b) What are the perceptions of Puerto Rican mothers who are victims of IPV on how exposure to IPV has influenced their primary school-age children? This chapter is organized into several sections which include the pilot study outcomes, relevant participant demographic data and characteristics, a description of data collection and data analysis procedures, the 50 themes identified, measures taken to ensure trustworthiness including intercoder reliability procedures, and a summary.

Pilot Study

The pilot study took place during the last week of March 2017 with the first three participants who met the eligibility criteria of being a mother over 18 years of age who was fluent in English or Spanish, had personal experiences with IPV, had a child aged 6 to 11 years of age who was exposed to the IPV, and agreed to two separate audio-taped interviews at a private and safe location without their children being present. The procedures followed for the pilot study mirrored the procedures of the main study which

included announcing the study, distributing fliers to community partners and having the participants contact me. All three of the participants were screened using the IRB-approved 10 question screening tool, provided with an introduction to the study including confidentiality procedures, and once they agreed to participate in the study, the time, date and place of the interview were arranged. At this point, I created an electronic password-protected legend in my password protected computer at my home office. I assigned each of them a unique identifier of A, B, and C. Each of the participants was contacted telephonically a week before the interview to confirm the date, time and location as well as their continued availability for the initial interview. All three interviews lasted 1.5 hours and the follow up interviews lasted approximately one hour each. The interviews took place in a private office at a local community organization which I had notified in advance to secure the private office space. The IRB-approved, panel-validated semi-structured interview protocol was used for the initial interviews once the participants had provided informed consent. Each participant was given a copy of the informed consent document for their records. Additionally, each of the participants received a $10.00 Target gift card at the beginning of the first and second interviews as a token of appreciation for their participation. I audiotaped each of the interviews with an app on my password protected iPhone and an Olympus WS-853 digital voice recorder. I indexed the interviews on each of the devices using the unique identifiers assigned to the participants. I had included the audiotaping of the interviews as part of the screening, eligibility and consent procedures. I also took brief handwritten descriptive and reflective field notes (Appendix G), with the participant's permission, and documented more in-depth notes

once they had exited on the observation sheet. The initial interview ended with a debriefing and the scheduling of the date, location and time for the second interview.

Upon my return to my home office, I secured each of the participants' manila folders in a locked cabinet in my home office. I updated the electronic legend with the date, time and location of the second interviews. I reviewed and transcribed each of the audiotaped interviews verbatim into a Word document on my password protected computer and stored them in electronic folders created for each of the interviewees using their unique identifiers. I also audited the transcripts, once they were initially transcribed, by listening to the audiotaped interview while reading the Word document to ensure the accuracy of the transcribed interview data and created a second copy. I edited the second copy of the transcript for grammar and stumbles but retained the words and meanings implied by the interviewees. I imported the edited transcripts into NVivo, and my handwritten field notes were transformed into memos for each of the participants and linked to each of the individual interviews in NVivo. The verbatim transcribed interviews were then copied and placed in each of the participant's folder for member checking during the second interview. Additionally, I used the transcribed interviews to create follow up questions and notate areas where clarification was needed, using the annotation feature in NVivo 11 Plus, for the second interview. I transcribed the questions into a Word document, stored it in each of the participant's folders in my home computer, printed them and placed them into each of the participant's manila folders. I also summarized interview, observational and reflective notes in a one-page contact summary form and used it as a planning tool to guide the research process as recommended by

Miles et al. (2014). The contact summary forms were transcribed into Microsoft Word and filed in each of the participant's electronic folders, printed and stored in their manila folders. I created a word document for each of the participants that reflected preliminary themes based on textural and structural descriptions as well as the essence of their experiences, printed it out and placed it in each of the participant's manila folders, and stored them in their electronic folders in my password-protected computer.

Furthermore, consistent with transcendental phenomenological approaches, I engaged in epoche and bracketing (Moustakas, 1994) prior to the interviews to ensure that I remained open to the subjective lived experiences as described by the participants (Creswell, 2013). I created a separate research journal memo in NVivo which I used to document my beliefs and values, and to self-reflect which is consistent with the emergent design characteristic of qualitative studies and reflexivity (Creswell, 2013; Ortlipp, 2008). Before, during and after the audiotaped interviews, I maintained a respectful, unbiased, nonjudgmental attitude and did not offer any personal advice.

Once I conducted the initial interviews, I arranged the follow-up interview times and dates with each of the participants. I notified the contacts at the location of the appointments in advance to secure the private office space. During the follow up interviews, I engaged in member-checking of the transcribed initial interview with each of the participants. They made no changes and this aided in establishing credibility (Lincoln & Guba, 1985). The second audiotaped interviews lasted one hour and consisted of open-ended follow up questions or clarification of answers provided in the first interview. Thus, the second set of questions was created based on the first interview. I

created questions by using the annotation feature in NVivo 11 Plus once I had transcribed the initial interviews and imported them into the software program. All of the pilot participants had requested to complete member-checking for the second interview by email. I emailed the de-identified transcribed interviews to each of them individually and requested that they review them and provide feedback, confirm or make changes to the text. The emails were sent with a delivery and read receipt using Outlook. A follow up call was placed to ensure receipt as well as the review of the transcribed interviews, attain feedback and answer any questions, but no changes were made by the participants.

One thing I realized after the first interview was that there weren't any tissues in the private office where I conducted the interviews. The lack of tissues prompted me to have to stop the first interview and search for tissues since the participant was tearful. Thus, not having the tissues readily available for future interviews may have contributed to the participants' physical discomfort in moments when they didn't have the emotional resources to tolerate it; this could have led to concurrent interruptions of the interviews and breaks in the momentum of descriptions of upsetting events. Thus, following the interview, I purchased several boxes of tissues and placed one on the table in the room. From then on, I kept a steady supply of tissues in the private office space. I also found that I had to redistribute fliers to my community partners to attain more participants. Conducting the pilot study provided me with opportunities to practice how to organize and manage the vast amounts of data and my time. The pilot study substantiated the appropriateness of the recruitment procedures, the screening tool, audiotaping devices, and the semi-structured interview protocol. It also provided me with an opportunity to

refine my interview and observational skills and test the research design. There were no changes in recruitment, instrumentation or data collection and analysis procedures made during or after the pilot study.

Setting

The setting for most of the initial and follow up interviews occurred at a local community organization in the New York City borough of the Bronx. I chose this setting because the participants were familiar with its location, the employees, it was safe, and they had counseling services available. For eight of the interviews, I used the same private office. It was furnished with three comfortable armless chairs, a small square table situated in the right corner of the room where I placed the tissues, and a small gated window with blinds which remained closed during the interviews for added privacy. In the office hanging on each side of the walls parallel to the door, there were two inspirational canvas works of art written in Spanish. One was titled *Exiting* and had a picture of a large white bird in the middle of two mountains by a lake, and the other one had two kids praying and was titled *Children Learn What They Live*. There was also a mirror hanging on the wall behind the corner table which several of the participants used to reapply their makeup after the interviews.

Additionally, at the request of one of the participants her initial and follow up interviews took place in her apartment located in the Bronx. The apartment building was under construction, but there was a side door which, when I opened it, led to a gray panel of apartment buzzers on the right. The participant buzzed me in, and I went through a second door and located two residential elevators which had a gray cloth lining covering

the inner shell. The participant warmly greeted me at her door and invited me in. The two-bedroom apartment was furnished, and we sat on a burgundy leather couch in the living room where there were several boxes, some pictures of her with her kids and a television. She thanked me for coming and stated that she preferred to be home when she discussed personal issues related to her experiences with IPV.

Throughout the study, there were no changes in personnel at the organization where the majority of the interviews took place, no budget cuts, and none of the participants suffered from any unnecessary trauma. Thus, there were no personal or organizational issues or conditions that may have influenced the participants or their experience at the time of the study.

Demographics

A total of nine self-identified single, divorced, and married Puerto Rican women participated in the study of whom seven were born in the United States but raised in Puerto Rican households. Eight of them were the biological mothers, and one was a grandmother and legal guardian of intimate partner violence-exposed children. The participant's age range was 27 to 56 years with a mean age of 36.8 years (SD = 9.4), which represents a range of 29 years. Combined they had a total of 31 children between the ages of two to 27 years of which 12 met the criteria of being aged 6 to 11 years and having been exposed to IPV. The mean for the total number of children was 5.2 (SD = 3.8) and the mean for the IPV-exposed children aged 6 to 11 years was 1.3 (SD = 0.7). Income variations were noted among the participants but derived primarily from a combination of Temporary Assistance for Needy Families [TANF] as well as

Supplemental Nutrition Assistance Program [SNAP] (78%), child disability benefits (11%) and Social Security Income (11%). Only one participant received child support from the fathers of her two children. The number of years of IPV varied from 1.5 to 16 years with a mean of 6.4 years (*SD* = 4.81). Demographic differences were also noted regarding their marital status, occupational status, and educational attainment of the participants.

In addition to differences in their demographic characteristics, the participants shared some commonalities. For example, all (a) were no longer involved in an intimate relationship with the perpetrator, (b) resided in New York City, (c) had sought help, (d) had IPV-exposed children between the ages of 6 and 11 years, (e) had experienced transitions from a domestic violence or family shelter to an apartment with their children, (f) self-identified as being Puerto Rican, and (g) considered themselves the head of their household. The demographic data derived from all of the participants is consistent with a greater than 51% rate of poverty among female-headed households with children based on a median income of $21,257 (New York State Community Action Association, 2014). Table 2 represents the relevant demographic characteristics of the participants.

Table 2

Socio-demographic Characteristics of Study Participants (N = 9)

Demographic Characteristics	N	Percentage (%)
Age (M, SD)	36.8	9.4
18-30	2	22%
31-45	5	55%
46-55	1	11%
56-65	1	11%
Occupation		
Homemaker	6	67%
Unemployed	3	33%
Country of Birth		
Puerto Rico	2	22%
USA	7	78%
Income		
<$10,000	7	78%
$10,000-$15,000	1	11%
$15,000-$20,000	1	11%
Educational Attainment		
< High school	2	22%
Some high school	5	55%
Training Certificate	1	11%
Associates Degree	1	11%
Marital Status		
Divorced	1	22%
Single	6	66%
Married	2	22%
Number of Children (M, SD)	5.2	3.8
1	1	11%
2	3	33%
3	1	11%
4	1	11%
5	1	11%
6	2	22%
Total Number of Children aged 6-11 years	1.3	0.7
1	7	77%
2	1	11%
3	1	11%

(table continues)

Demographic Characteristics	N	Percentage (%)
Years of IPV (M, SD)	6.4	4.81
1-5	4	44%
6-12	3	33%
13-18	2	22%

Data Collection

I initiated data collection procedures once I obtained approval from the IRB at Walden University. The pilot study consisted of the first three participants who met the predefined sampling criterion strategies, and I did not include their data in the main study. The recruitment and data collection processes were initiated with kick-off meetings which were arranged via email. I had already received three letters of cooperation from several domestic violence and community organizations in New York City who were willing to post my fliers and provide private office space for the interviews. One domestic violence agency declined to provide a letter of cooperation, so I omitted them from the study. A fourth domestic violence organization provided me with a letter of cooperation on March 13, 2017, and they were approved by the IRB to post the study fliers at their Bronx locations on March 15, 2017. Thus, in total, I coordinated face-to-face kick-off meetings with two community-based domestic violence organizations and two community organizations. The recruitment and data collection activities began on February 21, 2017, and ended on May 10, 2017, with the completion of intercoder reliability check and covered a timeframe of approximately 12 weeks. With the exclusion of the pilot study participants, I received calls and screened a total of 15 potential participants of which 13 met the study's criteria for inclusion and nine agreed to

participate. Among the nine participants, all of them attended the initial interview, and eight (89%) participated in the second interview.

I collected audiotaped in-depth interview data from the nine participants using the expert panel validated semi-structured interview protocol in their preferred language of English or Spanish (Appendix A & Appendix B). Two interviews were conducted in Spanish and seven in English. Additionally, 89% of the interviews were completed in a prearranged private office at the local community organization, and one of them took place in the home of one of the participants.

I began the initial interviews with a brief introduction to my background, proceeded with a review of the consent form (Appendix D & Appendix E), in their preferred language, which each of the participants signed and was given a copy. At the beginning of the first interview, each of the participants was given a $10.00 Target gift card and informed that the gift card was a thank you gift and theirs to keep regardless of whether they decided to withdraw at any time. A manila folder was created for each of the participants, labeled with a unique identifier (001-009) and included their screening tool, a copy of the observation protocol (Appendix G), a copy of the interview protocol, and their signed consent form. Additionally, the participants were provided with an envelope for the copy of the consent form and Target gift card. I used an Olympus WS-853 digital voice recorder, and a recording app on my password protected iPhone and the interviews were indexed on the devices using the unique identifiers assigned to the participants. I had included the audiotaping of the interviews as part of the screening, eligibility and consent procedures. During the interview, with the verbal agreement of the

participants, I collected brief handwritten observation notes which I documented on the observation protocol (Appendix G). The initial interview ended with a debriefing and the scheduling of the date, location and time for the second interview. Each of the initial interviews lasted no more than 90 minutes.

Upon my return to my home office, I secured each of the participants' manila folders in a locked cabinet in my home office. I updated the electronic legend with the date, time and location of the second interviews. I reviewed and transcribed each of the audiotaped interviews verbatim into a Word document on my password protected computer and stored them in electronic folders created for each of the interviewees using their unique identifiers. I also audited the transcripts, once they were initially transcribed, by listening to the audiotaped interview while reading the Word document to ensure the accuracy of the transcribed interview data and created a second copy. I edited the second copy of the transcript for grammar and stumbles but retained the words and meanings implied by the interviewees. I imported the edited transcripts into NVivo, and my handwritten field notes were transformed into memos for each of the participants and linked to each of the individual interviews in NVivo. The verbatim transcribed interviews were then copied and placed in each of the participant's folder for member checking during the second interview. Additionally, I used the transcribed interviews to create follow up questions and notate areas where clarification was needed, using the annotation feature in NVivo 11 Plus, for the second interview. I transcribed the questions into a Word document, stored it in each of the participant's folders in my home computer, printed them and placed them to each of the participant's manila folders. I also

summarized interview, observational and reflective notes in a one-page contact summary form and used it as a planning tool to guide the research process (Miles et al., 2014). The contact summary forms were transcribed into Microsoft Word and filed in each of the participant's electronic folders, printed and stored in their folders. I created a word document for each of the participants that reflected preliminary themes based on textural and structural descriptions as well as the essence of their experiences, printed it out and placed it in each of the participant's folders, and stored them in their electronic folders in my password-protected computer. Lastly, I also created a separate research journal memo which I used to document my beliefs and, values and to self-reflect, which is consistent with the emergent design characteristic of qualitative studies and reflexivity (Creswell, 2013; Ortlipp, 2008).

The second interviews were confirmed telephonically a week in advance and attended by eight of the nine participants. Participant # 004 confirmed her availability but did not show up for the second interview. I called her later that day and she agreed to reschedule it but when I called, a week prior, to confirm the rescheduled interview she refused. Thus, I met with seven of the eight participants individually in a private office at the local community organization and with one of them in her apartment.

At the beginning of the second interview, I obtained verbal consent that they still wanted to participate in the audiotaped interviews and provided them each with the $10.00 Target gift card in an envelope. I explained that the gift card was a thank you gift and that they were entitled to it regardless of whether they decided to withdraw during the interview. I provided each of the participants with the Word document copy of the

transcribed interviews and preliminary themes, had them read both documents and asked if they had any questions or wanted to make any changes. None of the participants made any changes. I proceeded with an explanation that the purpose of the second interview was to seek clarification and have them answer several additional questions that I had derived from the first interview. The number of open-ended questions for the second interview ranged from 14 to 20. I used an Olympus WS-853 digital voice recorder, and a recording app on my password protected iPhone and the interviews were indexed on the devices using the unique identifiers assigned to the participants. To differentiate between the first and second interviews, I added a dash two (_2) to the assigned unique identifier in the recording devices. During the second interview, with the verbal consent of the participants, I collected brief handwritten observation notes which I documented on a second observation protocol (Appendix G). The second interview ended with a debriefing and a discussion of their preference for member checking of the transcripts within a week. Six of the eight participants expressed the desire to have the interviews emailed to them and agreed that I could email them two days later to determine if any changes needed to be made. Two of the participants declined to participate in member checking of their second interviews.

Each of the second interviews lasted no longer than 60 minutes. I reviewed and transcribed each of the audiotaped second interviews verbatim into a Word document on my password protected computer and stored them in the electronic folders I had initially created for each of the interviewees using their unique identifiers. The transcribed second interviews were electronically labeled as dash 2 (_2) after each of the participant's

assigned unique identifier. Again, I audited the transcribed interviews by listening to each of the audiotaped interviews while I read the Word document to ensure the accuracy of the transcribed interview data and a second copy was created. The second copy of the transcript was edited for grammar and stumbles, but retained the words and meanings implied by the interviewees. The edited transcripts of the second interviews were imported into NVivo 11 Plus, and my handwritten field notes were transcribed into new memos and linked to each of the participant's second interviews. I created a word document for each of the participants that reflected preliminary themes based on textural and structural descriptions as well as the essence of their experiences, printed them out, placed them in each of the participant's manila folders, and stored them in my electronic folders. The verbatim Word document transcripts and the preliminary thematic findings were emailed to the six participants a week after having completed each of the second interviews. I sent the emails with a delivery and read receipt to ensure that they were received and opened using Microsoft Outlook. All of the emailed documents were de-identified. Member checking on the second interviews and the textural and structural themes derived from their individual data were conducted during the week of April 24, 2017. Two of the participants emailed me within one day, and I followed up with the remaining four participants via email two days after receiving the delivery and read receipts to inquire about the need for any changes. None of the participants made changes to the transcribed interviews, and all agreed on the textural and structural themes derived from the combined interview data. Lastly, I engaged in reflexivity by documenting in my research journal which I had created in NVivo (Creswell, 2013; Ortlipp, 2008). I did not

make any variations to the data collection plan outlined in chapter 3, and there weren't any unusual circumstances encountered during the data collection process.

Data Analysis

The data analysis phase, which followed Moustakas' (1994) transcendental phenomenology guidelines, was based on the research questions and began during data collection using constant comparison techniques (Creswell, 2013; Patton, 2015). I started the process by using a journal where I documented my experiences with the phenomenon, self-reflections, and biases throughout all phases of the study. The process provided me with the ability to bracket my own experiences with child IPV exposure and remain open to the lived experiences of the participants.

I listened to each of the audiotaped interviews and transcribed them verbatim onto a Microsoft Word document. I then audited each of the transcribed documents by reviewing them as I simultaneously listened to the audiotaped interviews. Once I had confirmed that I had transcribed the interviews verbatim, I read, created and edited the second copy for grammar and stumbles. When I transcribed the interviews, I included each interview question with the corresponding data collected from the participant. I imported the edited copies of each of the interviews individually into NVivo 11 Plus using the sources tab after member checking had been completed. Member checking was completed within a week of the initial interviews and imported into NVivo. I reviewed each of the interviews again and created demographic classifications in NVivo. The same process was followed for the second interviews. As I immersed myself in the field notes and interview data, I used the process of horizonalization by focusing on compelling

statements, quotes, and sentences made by the participants to capture the essence of their lived experiences as they related to the phenomena (Moustakas, 1994). The interview, reflective notes, and memo data were organized into broad, meaningful clusters of how the participants experienced the phenomenon for open coding (Creswell, 2013; Miles et al., 2014; Miles & Huberman, 1994; Saldaña, 2016). I engaged in open coding by creating nodes, using NVivo 11 Plus, based on what was emerging from each of the participant's interview data. The coding was descriptive, category based and analytical which allowed me to create new categories (Rudestam & Newton, 2015). Also, new nodes were developed, coded and categorized as different themes emerged. The coded clusters were further evaluated, reduced to a series of significant statements, then grouped into themes (Creswell, 2013; Miles et al., 2014; Miles & Huberman, 1994). In this way, distinctive textural and structural themes were derived from the participants' experiences as a whole to capture the essence of the experiences of the group (Moustakas, 1994). These strategies are consistent with transcendental phenomenological approaches, the research questions, the data collected, and emphasize what is conceptualized about the study (Creswell, 2013; Miles et al., 2014; Miles & Huberman, 1994). Discrepant cases were further analyzed and disclosed in the results section of Chapter 4 and in the final write-up in Chapter 5 (Miles et al., 2014; Patton, 2015).

Also, I utilized the summarized interview, observational and reflective notes from the contact summary form (Miles et al., 2014). The document helped me focus and reflect on the written and corrected field notes (Creswell, 2013; Miles et al., 2014). The aggregation process also allowed me to formulate a preliminary interpretation which was

also used to code data into themes (Creswell, 2013) in NVivo. I had also created a case dynamics matrix for each of the participant's interviews which assisted me in determining preliminary explanations based on the research questions (Miles et al., 2014). In total, I coded 127 statements, sentences and quotes from the 17 interviews derived from the nine participants. Thus, both content and thematic analysis procedures were used throughout the data analysis phase (Patton, 2015). Additionally, as part of data analysis, I intergrated intercoder reliability procedures with a research assistant. The research assistant coded each of the transcribed interviews independently in NVivo and I followed the same procedure of coding each of the interviews independently. I then compared our findings by running a coding comparison query in NVivo 11 Plus and the Kappa coefficient was .902, and the percentage agreement was 99%. Indicating a high level of reliability.

NVivo

I chose to utilize the student version of NVivo 11 Plus because it accommodated my needs for securely storing, organizing and managing the data for analysis (Bazeley & Jackson, 2013; Creswell, 2013). NVivo facilitated the manipulation of the data through coding as well as categorizing and had several built-in auditing and graphic features which I used to represent the data visually during analysis (Creswell, 2013). NVivo also provided me with a higher level of structure and organization than the case matrix alone (Creswell, 2013; Patton, 2015). However, my use of a case-matrix, as well as NVivo, provided me with optimal inductive and logical opportunities to explore outliers, identify follow up surprises, assess competing explanations, and make if-then tests which enhanced credibility (Miles & Huberman, 1994; Patton, 2015).

Results

Introduction

The steps above allowed me to analyze and cluster the data into 50 themes that fit the research questions and overall goals of this study which were to understand the lived experiences of Puerto Rican mothers who have been victims of IPV and their perceptions of how IPV has impacted their IPV-exposed children aged 6 to 11 years. The themes which materialized from the data are fundamental to understanding the phenomena.

The 50 clustered themes that emerged from the data are summarized below and presented with codes in Table 3. The approach I took to gain a better understanding of their experiences included dividing the topic of their experiences with the IPV when they were in the relationship and post-separation.

1. Most of the mothers endured an array of IPV which escalated over time.
2. Many mothers attempted to avoid escalation of IPV incidents.
3. Most of the women verbalized that their relationships were not initially abusive.
4. Most of the mothers noted that fear, emotional and physical disabilities influenced employment.
5. Most of the mothers had encounters with ACS.
6. Most of the mother's had to choose whether to disclose IPV when screened and feared ACS involvement or being judged.
7. Once separated, most found themselves isolated and living in shelters which were not conducive to rearing their children.

8. For some mothers, the perpetrators had discovered where they lived and had threatened them.
9. Many of the mothers had experienced trauma and parental substance abuse during their childhood.
10. Many of the mothers had family responsibilities at a young age, became pregnant during their teenage years and dropped out of school.
11. All of the mothers felt that family unity was important to them.
12. Many of the mothers were warned by their family members about their ex-partner.
13. All stayed in the relationship because they wanted to keep the family unit together.
14. The majority of mother's left because they feared for their lives or because of the effects witnessing IPV had on their children.
15. All of the mother's blamed themselves for their children's exposure to IPV.
16. All of the mothers were committed to protecting and making their children a priority.
17. Several of the mothers taught their children life skills.
18. All of the mothers discussed goals for themselves or their children to have a better life.
19. Several of the mothers pass on Puerto Rican values and traditions with their children.
20. All of the mother's had one or more sources of external support.

21. Most of the mother's had challenges navigating the system.
22. Many of the mothers described having challenges with trusting others.
23. A few mothers learned positive lessons from the system.
24. Despite separation, many of the mothers had continued emotional, mental health and physical challenges.
25. Several of the mothers had developed positive coping mechanisms.
26. Many of the children were exposed to verbal and physical IPV in utero and at an early age.
27. Most of the mother's described that their children were old enough to understand.
28. Fear, anger, internalizing and externalizing behaviors were common in the children.
29. Many of the children showed caring towards their mother's post IPV incidents.
30. Some of the children had continued instability post-separation.
31. Improvement in academic performance were evident among the IPV-exposed children.
32. Post-separation the children were mostly showing signs of coping, an internal asset.
33. Most of the children depicted actions of being responsible, trusting and hopeful.
34. Some of the children had health issues which they were being treated for.

35. At some point, all of the children had a symptom associated with PTSD.
36. The majority of the children received counseling post-separation and some have continued counseling.
37. Several children interacted regularly with friends and school personnel.
38. The mother-child relationship was perceived to be robust.
39. Many of the children had close relationships with siblings, family figures and family members.
40. Most of the children confided in their siblings about the IPV.
41. Some of the children were involved in extracurricular activities.
42. Most of the perpetrators were the biological fathers of the IPV-exposed children.
43. Most of the perpetrators tried to control the children.
44. Alcohol and illegal drug use by the perpetrator played a role in IPV for most of the participants.
45. Most of the children don't have contact with the perpetrator.
46. A few children had or wanted to have contact with the perpetrator.
47. The majority of the perpetrators didn't have visitation or pay child support.
48. The mothers were empowered to help others by sharing some of their insights.
49. Some of the mothers want transparency with IPV screening procedures.
50. Most of the mothers provided feedback on resources that are lacking for themselves and their children.

Table 3 *Emergent Themes regarding Intimate Partner Violence Experiences*

Codes	Themes
Relationship duration IPV initiation and escalation Resistance and returning Effect on employment Administration for Children's Services Shelters Being in hiding Living in fear IPV Screenings	Most of the mothers endured an array of IPV which escalated over time. Many mothers attempted to avoid escalation of IPV incidents. Most of the women verbalized that their relationships were not initially abusive. Most of the mothers noted that fear, emotional and physical disabilities influenced employment. Most of the mothers had encounters with ACS. Most of the mother's had to choose whether to disclose IPV and feared losing their children. Once separated, most found themselves isolated and living in shelters which were not conducive to rearing their children. For some mothers, the perpetrators had discovered where they lived and had threatened them.
Abuse in past relationships IPV exposure/ Parental drug use/ Child abuse Acting out, grew up early, teenage pregnancies	Many of the mothers had experienced trauma and parental substance use during their childhood. Many of the mothers had family responsibilities at a young age, became pregnant during their teenage years and dropped out of school.
Familismo (Familism) Warning Rejection Protection Marianismo (female marital role expectations) Help-seeking Hope Self-blame Teach practical skills Caretaking Reason for living Empowerment Traditions Language, respect, celebrations	All of the mothers felt that family unity was important to them. Many of the mothers were warned by their family members about their ex-partner. All stayed in the relationship because they wanted to keep the family unit together. The majority of mother's left because they feared for their lives or because of the effects on their children. All of the mothers blamed themselves for their children's IPV exposure. All of the mothers were committed to protecting and making their children a priority. Several of the mothers taught their children life skills. All of the mothers discussed goals for themselves or their children to have a better life. Several of the mothers passed on Puerto Rican values and traditions with their children.
Counseling Community Faith Friends System-legal, school, government programs	All of the mother's had one or more sources of external support. Most of the mothers had challenges navigating the system. Many of the mother's described challenges trusting others. A few mothers learned positive lessons from the system.

(*table continues*)

Codes	Themes
Coping mechanisms Illnesses Emotions Stress	Despite separation, many of the mothers had emotional, mental health and physical conditions. Several of the mothers had developed positive coping mechanisms.
Onset Types of exposure Verbal and physical abuse Old enough to understand or too young	Many of the children were exposed to verbal and physical IPV in utero and at an early age. Most of the mother's described that their children were old enough to understand.
Anger and fear Continued instability Externalizing and internalizing behaviors Performance in school Rare negative behaviors Intervening	Fear, anger, internalizing and externalizing behaviors were common in the children. Many of the children showed caring towards their mothers post IPV incidents. Some of the children had continued instability post-separartion. Improvement in academic performance were evident among the IPV-exposed children.
Internal Assets Coping skills Outspoken Show care for others Health/ Triggers Developmental tasks Hope Trust External resources Counseling Friends Family Mother-child relationship Extracurricular activities School	Post-separation the children were mostly showing signs of coping, an internal asset. Most of the children depicted actions of being responsible, trusting and hopeful. Some of the children had health issues which they were being treated for. At some point, all of the children had a symptom associated with PTSD. The majority of the children received counseling post-separation and some have continued counseling. Several children interacted regularly with friends and school personnel. The mother-child relationship was perceived to be robust. Many of the children had close relationships with siblings, family figures and family members. Most of the children confided in their sibling's about the IPV. Some of the children were involved in extracurricular activities.
Characteristics Substance abuse Expectations for child visitation Tactics Behaviors towards the children Child contact and feelings towards perpetrator	Most of the perpetrators were the biological fathers of the IPV-exposed children. Most of the perpetrators tried to control the children. Alcohol and illegal drug use by the perpetrator played a role in IPV for most of the participants. Most of the children don't have contact with the perpetrator. A few children have or want contact with the perpetrator. The majority of the perpetrators don't have visitation or pay child support.

(*table continues*)

Codes	Themes
Insights gained	The mothers were empowered to help others by sharing some of their insights.
IPV screening practices	Some of the mothers want transparency with IPV screening procedures.
Resources	Most of the mothers provided feedback on resources that are lacking for themselves and their children.

Discrepant Cases

Cross-case, if-then tests and repeated analysis were performed for all cases to capture any discrepancies. One discrepant case was further analyzed and disclosed (Miles et al., 2014; Patton, 2015). In this case, the Participant 005 stated, "I think the PTSD is from them being in and out of the shelters and ACS". I included the case discrepancy in the results section of Chapter 4 and the interpretation section of Chapter 5 as evidence of other factors that may have some impact on the issue.

Evidence of Trustworthiness

The trustworthiness of a research study requires the researcher to apply strategies that involve the establishment of four criteria which include credibility, transferability, dependability, and confirmability (Creswell, 2013; Lincoln & Guba, 1985). They are viewed as naturalistic or qualitative research equivalent to reliability and validation approaches used in quantitative research (Creswell, 2013).

Credibility

Credibility represents the internal validity of the underlying assumption that the findings provide an authentic description of reality based on the perspectives and experiences of the participants (Creswell, 2013; Lincoln & Guba, 1985; Trochim, 2006). It's "a process of checking, questioning, and theorizing…" that isn't based on rules

(Miles and Huberman, 1994, p. 279). I used six strategies to assess credibility in this study including journaling, consensual validation, the use of multiple sources of data for triangulation, member checking, peer review, and saturation.

Before data collection, I engaged in self-reflection using a journal I created in NVivo as a bracketing procedure to reduce biases or presuppositions and enhance objectivity (Creswell, 2013; Maxwell, 2005; Miles et al., 2014). This allowed me to be open to the participant's lived experiences without judgment or assumptions (Creswell, 2013). I also provided a private, comfortable and relaxed environment which enhanced open and honest communication (Creswell, 2013). I engaged myself in the process of consensual validation by making judgments about what was meaningful and substantively significant in the data based on the reports of the participants (Patton, 2015). I provided them with ample time to answer the questions and didn't give any advice or offer them any opinions. I also integrated data triangulation by corroborating the findings from each of the participants' and conducted an analysis of potentially negative cases (Miles & Huberman, 1994).

Furthermore, to verify the accuracy of the data, a printed copy of the verbatim first interview and the preliminary themes was provided to each of the participants during the second interview for consensual validation using member checking. During the second interview, they were each asked to read the documents and provide feedback on whether or not they were in agreement with their individual transcript and themes. The participants who had limited reading literacy levels, requested that I read the interviews to them verbatim. Eight of the nine participants participated in member checking because

one of the participants refused the second interview and I wasn't able to reach her for member-checking. The second transcribed interviews, and preliminary themes were emailed, per their request, to six of the participants and the remaining two participants refused to meet with me for member checking of their second interviews. I queried the participants who received the transcribed interviews with the preliminary themes via email within a week for feedback. None of the participants made any changes to the transcripts or preliminary themes of their first or second interviews. Thus, the rate of member checking for the first and second interviews was 89% and 67%, respectively.

Additionally, the Chair and methodologist who comprised my dissertation committee also reviewed my study's procedures and results per Moustakas (1994) data analysis methods. The methodologist has expertise in qualitative validation procedures. Thus, this process served as a peer review of the procedures I integrated to address quality issues related to credibility.

Lastly, credibility was also addressed using the principal of saturation which dictated a number of interviews that were necessary. Saturation, the point where there are no new emerging themes or issues (Fusch & Ness, 2015; Mason, 2010), was approaching by participant # 005 and reached at participant # 007. At this point, coding had become repetitive, and no new information was being attained, so I consulted with my committee chair who confirmed that saturation was met. However, two additional interviews were conducted to ensure that the data was sufficient.

Transferability

The characteristic of transferability in qualitative research refers to the generalizability of the findings regarding other contexts or different settings (Lincoln & Guba, 1985; Patton, 2015). To enhance transferability, I described the context and assumptions of my study by using thick descriptions of the individuals who participated, the settings where the research took place, and the procedures that were used to support the findings in detail (Lincoln & Guba, 1985). I provided the relevant demographic characteristics of each of the participants and documented field notes during and after each of the interviews. Additionally, I illustrated the detailed steps that were taken for the study including recruitment, the setting, data collection, and data analysis procedures. Thus, the information provided will equip other researchers to make a determination as to the transferability of the results among other contexts or settings (Lincoln & Guba, 1985). Nonetheless, generalizability might be constrained because this study is limited to adult Puerto Rican mothers who have been victims of IPV and have children aged 6 to 11 who have been exposed to IPV in the Bronx borough of New York City. Regardless of this limitation, the audiotaped, electronic and paper documents derived from this study will be securely stored for five years in the event that other researchers may want to review it.

Dependability

Dependability relies on the consistency of the context of the qualitative research study and reflects its reliability (Trochim, 2006). I established dependability through audit trails, by concretely describing the study's design as well as its implementation and by triangulation. The raw data I collected (audiotaped recordings and field notes) were

the root items from which the analysis and final results were derived. I kept a manila folder for each of the participants which contained the handwritten notes, the screening tool, interview protocol, and consent for each of the participants stored in a locked cabinet in my home office. The audiotaped interviews and the field notes were downloaded and transcribed verbatim electronically in Microsoft Word into my password protected computer and stored in a separate folder for each participant. I also audited the interviews by reading them while I listened to the recording and kept an electronic copy of the transcribed verbatim interview. I then made another copy of the interviews which I edited for stumbles and grammar. The recordings and the edited transcribed interviews were imported into NVivo 11 Plus. In NVivo, a memo was created and linked to each of the participant's interviews. In the linked memos, I documented the detailed field notes which included my observations of the setting, participant, any insights gained and some interpretations. Additionally, I created annotations directly in NVivo for each interview depicting the areas where I needed clarification or had questions for the second interview. The questions from the annotated notes were copied and pasted into a Microsoft Word document, electronically stored in each participant's folder, printed and placed into the individual manila folders. As I read through the interviews, they were coded and reduced into themes in NVivo. NVivo 11 Plus has a built-in audit trail which allowed me to manage and organize the data from the transcribed interviews into nodes, codes, and themes (Bazeley & Jackson, 2013).

A legend was also created with the names of the participants, their unique identifier, contact information, dates of calls, and the dates of the first and second

interviews on an Excel spreadsheet and stored in my password protected computer. I documented reflexive notes in a journal stored as a separate memo in NVivo. Also, I also provided a detailed description of how all the data was gathered and the process of inquiry that was used throughout the study which supplemented the reliability of the study even further. Lastly, I took steps to interact with the participants in a meaningful manner through the utilization of open-ended questions.

Confirmability

The characteristic of confirmability in qualitative research reflects a positivist viewpoint of objectivity. Confirmability strategies aid in ensuring trustworthiness and that the findings represent the experiences of the participants and were not based on my preferences or own ideas (Shenton, 2004). Audit trails, triangulation, and reflexivity were integrated into this study to assure its confirmability. In NVivo, I kept a journal where I documented my ideas and the rationale for the decisions I made. I also documented my thoughts, feelings and any biases I had throughout the study. Thus, I was astutely aware of my experiences with IPV between my parents when I was a child and the long-lasting effects it creates in some individuals. For example, in my own family, I have seen that resilience can vary even among people who grow up in the same environment. I proposed that social support would help overcome some of the risks associated with adverse childhood experiences as they pertained to IPV exposure among children. However, I was also aware that the literature was lacking what and how Puerto Rican mothers' lived experiences were and how they perceived exposure would impact their child aged 6 to 11

years. Therefore, I remained open to the stories described by the participants, listened, audiotaped and wrote with rigor, and examined the themes as they emerged.

Intercoder Reliability

Intercoder reliability is an analytic method which enhances the internal and external validity of the findings (Creswell, 2013). It entails the utilization of triangulating analysts and provides an external means for reviewing the quality as well as the accuracy of data collection processes and analysis (Creswell, 2013). Thus, intercoder reliability aids in ensuring quality and reliability (Creswell, 2013; Miles & Huberman, 1994; Patton, 2015).

Independent coding procedure. I attained an independent research assistant (RA) on April 13, 2017, who signed a confidentiality agreement which was approved by the IRB on April 20, 2017. The RA was provided with the de-identified transcripts of all of the initial and second interviews which she coded and analyzed independently in NVivo 11 Plus and returned to me on May 5, 2017. By this point, I had also independently coded and thematically analyzed all of the interviews in NVivo 11 Plus. On May 6, 2017, I consulted with my Chair who advised me to run a coding comparison query through NVivo, so I could ascertain the Kappa coefficient and percentage agreement. Using NVivo, I imported the dataset from the research assistant, merged it with my dataset and ran the Coding comparison query for all coded nodes and themes derived by both users (Group A and Group B). The Kappa coefficient was .902, and the percentage agreement was 99%. Thus, based on the Kappa coefficient and the percentage agreement no revisions to the codebook were required.

Also, I used memoing as well as if-then tests in the field during data collection to determine the consistency or lack thereof, of identified pattern codes. I accomplished this by seeking feedback from the participants during the first and second interviews and through member-checking. I found that the participants were able to verify my predictions of the patterns of codes and themes derived from their interviews.

There were two adjustments made to the strategies described in chapter three. First, I contacted several Walden University faculty members, the research center staff, the IRB, and posted a request on the Walden University group discussion portal but was unable to locate a research assistant from the University. Therefore, I attained a research assistantt from an outside organization. Additionally, since the high Kappa coefficient and percentage agreements derived from the Coding comparison query exceeded my goal of achieving a .80 (80%) intercoder coefficient agreement for coding and broad thematic analysis, there was no need to compare notes or share the concept map I had created.

Themes by Research Questions

The themes will now be described in detail and supported with evidence from participant specific statements. Highlighting the essence of the participant's IPV experiences and their perceptions of how IPV exposure has impacted their IPV-exposed children aged 6 to 11 years. Research Question 1**:** What are the lived experiences of Puerto Rican mothers who are victims of IPV?

Theme 1: Most of the mothers endured an array of IPV which escalated over time.

The first theme identified related to the categorized types, initiation, and duration of IPV experiences of the participants. All nine of the participants met the criteria of

having been victims of IPV by a former intimate partner and were no longer in the relationship. They described their experiences with being battered by their former partner in detail. All of the participants openly shared their experiences of abusive episodes. Participant 008 described, while crying, that during her two-year relationship, her spouse "would break the windows in the apartment, would check on me thinking I was with other men, would threaten to kill me, held a gun to my mouth, took my money, and he would even check my underclothes." Participant 009 recounted, as she shook her head in disbelief and wiped her tears, her experiences with IPV that were perpetrated by her live-in boyfriend of 5 years when she got pregnant with his child. She stated:

> I got pregnant, and that's when things got worse. He used to hit me a lot, and I was scared. He was verbal, physical and raped me. The physical abuse was so bad he would rip my nails off, bite me, kick me until I bled, pull my hair, and bang my head against the wall. One day he even tried to burn me with hot water while I was in the shower and boiled grease to pour it on me. There were many times I thought I was going to die. He would get mad about everything including what I was wearing. I couldn't talk to anyone in my family not even my children in the house. He would lock me up in the room and only let me out to cook. He even punched me in my left eye to the point where I needed surgery. He would pinch me, choke me and he beat me the entire time I was pregnant with my youngest daughter. There were many times I thought I was going to die.

Participant 005 reported that in her relationship with the father of her four children:

> There was one incident with me and the four kids father weren't together and I happen to bump into him one day and I wanted to know what was going on like these kids need a mother and a father and why he wasn't taking care of the kids. So, he tried like to walk away from me and I mean so I grabbed him by the shirt and he decided to hit me in front of the kids and then after that he just left and left us there. The abuse in the relationship I think was mental-fighting and stuff like that-arguing with each other.

Participant 001 described an episode where she feared for her life. She described the IPV experience:

> The last thing he tied me up in a chair and tied my kids up saying that he was going to kill us. I don't know how I got out of that chair but I did. I ended up hitting him in the head with a pot, left my kids there because I know he wasn't going to hurt my kids, and came back with the police but he was gone. At that point I knew I had to leave.

Eight of the participants experienced ex-perpetrator patterns of escalating abuse over the timespan of their relationships. Participant 002 stated, "Some people downplay it when they're pushed or grabbed so I can look back and say that it escalated with verbal abuse, pushing, grabbing my arm, pulling my hair and then over time it just got crazy." Participant 003 stated, "During my pregnancy, his controlling behaviors escalated, and he got very over protective, and that's when I started putting two and two together." Participant 004 described how the abuse she endured over a five-year time frame escalated "It was verbal, mental physical abuse but mostly it was just mental and verbal

than physical abuse. It started as verbal then it went to mental then it went to physical." Participant 006 who was married for 16 years, stated:

> Everything, in the beginning, was fine, and we used to do things together as a couple. Then, things got to a point where he didn't want to go out with me, so I used to go out alone and that's when the jealousy and controlling behaviors started. After my daughter was about a year old was when he changed and became aggressive.

Theme 2: Many mothers attempted to avoid escalation of IPV incidents.

The second theme emerged from coded data related to the attempts they made to deescalate the IPV which included resisting, covering up, attempting to leave, and returning to the perpetrator. The majority of the participants ($n = 5$) described some of the actions they took to resist and most of mothers had returned to the perpetrator after having left him at some point during the relationship. Despite their IPV experiences, all of them had on and off relationships with the perpetrator because they were misled by the perpetrator and had hope for change. Unfortunately, such issues are typical in the cycle of abuse particularly during the making-up phase (Domesticviolence.org, 2015). Participant 002 stated,

> My reaction when I thought it was going to get physical was to go in the room and tell my daughter that this is not what a man should treat her like. In my relationship, things got worse when I stopped having sexual relations with him… we were no longer intimate for about 1.5 years because I didn't want my daughter

> to see me in bed with him afterward because I didn't want to give that example to my daughter. That's why I checked out mentally.

Participant 004 said that during verbally abusive episodes:

> …me being a Puerto Rican, I would not stay shut I would defend myself because all my life I defended myself. So he would tell me something, and I would tell him back. So it was like a back and forth thing. Every time we'd break up he'd tell me the same thing and two to three months down the road it would go back to the same thing.

Participant 001 stated,

> Nobody knew what I was going through nobody knew because I always had a smile on my face, but inside I was dying. I didn't want anybody to get in trouble because of me, so I kept it to myself. When we would argue and they would ask "what's going on" I would just tell them we had an argument. I have a kid who is autistic and he's really attached to his father. He tried to hurt himself a couple a times when I tried to get away from the relationship so for his being, I stuck with it. That's the 13 year-old. I started getting a little strong by hiding my money and not letting him know what I do with the money because if I would've let him know he would go ballistic so I wouldn't keep nothing there.

Participant 009 described how she returned with the perpetrator, after having separated from him, she stated,

> I saw him for about five days, and they (the kids) didn't know where I was going. We were living in the shelter. One day, my 11 year-old was with me, and he was

> following us, and that's when she saw him. She pointed to him, and she asked if we had to run. I told her not to worry because he wasn't going to hit me. When he came up to us, she told him to please not hit her mom. He apologized to her, and she said she would give him one more chance. My 11-year-old asked why I had kept it a secret that I had seen him before. She said she hoped that this time he wouldn't kill me because it needed to stop and I explained that he had changed and things would be different this time.

Participant 006 described how she resisted by migrating to New York and left her perpetrator in Puerto Rico, she said,

> My way of leaving him was to tell him that I was coming to New York to seek help for our daughter and he agreed. He was under the impression that he would come to New York or that I was returning to Puerto Rico. Once I got here, I lived in a shelter, settled into an apartment and had already planned on staying away from him since the beginning when I left.

Theme 3: Most of the women verbalized that their relationships were not initially abusive.

The third theme related to categorized codes regarding the beginning and duration of their IPV relationships. Most of the participants ($n = 7$) verbalized that the relationships were not abusive initially and 44% discussed how they had experienced controlling behaviors during courtship or were warned by others but were blinded by love despite the warnings. Participant 003 stated,

> I met my partner when my son was three months old, he seemed nice at first, but I caught him lying about being with other woman when we were first dating. He started changing after six months, and it began with him being jealous of my relationship with my family.

Participant 004 stated,

> This is what I'm saying, he was nice in the beginning but after his father passed away is when he changed. So I think the passing of his father cause the guilt of him not being a good son and not being there for his father helping his mom and his father like a good son but he didn't. I thought I was in love…I just had blinds but I took him back. You know how they put a blindfold in your eyes, I was blind for a couple of years and then they just took it out and I said to myself "what am I doing?"

Theme 4: Most of the mothers noted that fear, lack of support, emotional and physical disabilities influenced employment.

The fourth theme was categorized from codes which related to the mother's demographic data which included employment and the effects that IPV had on their employment. During the first interview, the mothers were asked about their employment and the data was coded based on whether they were employed, had been employed or were no longer employed. Five of the nine participants (56%) reported that their experiences with IPV affected their employment in various ways which included the perpetrators controlling behaviors in the workplace, physical ailments, embarrassment, and lack of support. Participant 001 discussed that her partner of 12 years,

> He would go to my jobs with his jealousy. He would do it everywhere I would work, and it was nonstop. He would start throwing stuff in there, and he got arrested a couple of times. My employer would say that they couldn't have that there so I'm sorry, but you're dismissed.

Participant 007, who had a culinary training certificate and worked in the field, noted that her partner threatened to go to her job and she,

> got nervous because I didn't want to lose my job or get embarrassed so I made up a story, and I left work…I went upstate with my family for three months and lost my job. I stopped working after I became a single mom from day one. I didn't really have the help that I needed, so I just sacrificed and put all my time into my daughter.

Participant 009 discussed that before her relationship with the perpetrator "I had been alone for six years working, paying my bills on time and taking care of my kids" but she did not discuss when or why she stopped working. Thus, at the time of the first and second interviews, none of the participants were employed. All of the participants relied on various federal, state and grant funded programs to support themselves and their children. In 2012, the maximum TANF allowance for one parent with two kids living in New York was $770.00 monthly which was comparable to a 50% poverty-level income (Falk, 2014). TANF benefits combined with $339.00 of SNAP benefits monthly, totaled $1,109.00 per month and was equivalent to 70% of the Federal Poverty Level (Falk, 2014). Despite financial hardships, Participant 001 stated, "I buy them stuff to keep their

mind busy rather than spend the money on myself. There are times when I take them out with a friend but money is tight so I haven't done that in a long time."

Theme 5: Most of the mothers had encounters with ACS.

Theme five codes related to the mother's encounters with ACS and their experiences. In New York State the issue of children who witness domestic violence in their homes including the circumstances that constitute witnessing isn't addressed in the New York State Child Protective Services Act of 1973 (MCKinney, 1976). ACS is responsible for providing preventive and foster care services to at-risk families by partnering with external nonprofit organizations to enhance stabilization (City of New York, 2016). Out of the nine participants, 5 of them had experiences with ACS involvement. Participant 004 discussed that when she lived at the shelter, she felt her children "…were depressed, but ACS said they weren't depressed." She did not go into details as to the extent of her involvement with ACS. Also, while living in a shelter, Participant 009 reported that when she was arguing with her daughter "They called ACS and my kids told them everything about the abuse when they came." Participant 001 said that while she was still in the relationship, ACS got involved and removed her oldest child from her home into her mother's house "because he hit my son with a bat over the head, the 15 year-old." Participant 002 discussed that her young daughter had called 911 when her father passed out, and she was out shopping, she stated:

> When I was in the relationship, I got an ACS case, but it wasn't my fault it was his. As a mom, I had to come in there with a broom and dustpan and clean it up. It

> was because of his alcohol. The cops told me that I had a choice of leaving or they would come and get the kids if I stayed.

Participant 005 had multiple encounters with ACS and had ongoing preventive services, she stated,

> The first time ACS got involved, my younger sister was mad at my mother, so she went to school and complained that me and my mother were doing drugs. So when they came to take away my sister's, I was living there with my daughter, so they took her too. I could've gone with her to foster care but I wasn't given the option, and I didn't know my rights. Eventually, her father took her because we did our parenting together. I was honest and told them that I was smoking marijuana and they didn't give me a chance to go into a program. I had ACS issues with the other kids, I had preventive services, and at the time when he hit me, the preventive worker called ACS on me. The last time ACS came, it was because of DV, and the cops called ACS. They came two days later to get my kids. I don't like when they come on the weekends because I don't find out where my kids are until Monday. They were concerned about the DV and possible abuse. I never allowed him to hit my kids so this was the first time it had ever happened.

ACS had investigated and removed the at-risk children from the households of three of the nine participants. Two of the participants had weekly two-hour supervised visitation sessions with their children, and the third participant's son refused to move

from her mother's house when she separated from the abuser. All three of the participants whose children were not with them spoke to their kids on a regular basis.

Theme 6: Most of the mother's had to choose whether to disclose IPV when screened and feared ACS involvement or being judged.

The sixth theme was coded from their pre and post-separation experiences with IPV screenings. When discussing ACS many of the participants spoke about their experiences with being screened for IPV when they were with the perpetrator and post-separation which is a USPSTF (2013) recommendation. During the second interview, four of the women reported having been screened for IPV by a physician, two stated they had never been screened and the remaining two mother's verbalized they were screened by domestic violence organizations. Participant 003 noted that she was screened in the hospital, when she sought medical attention for an IPV related injury, she verbalized:

> Other than that one time in the hospital when I had the concussion, I haven't been screened by a doctor. The police insisted that I tell them the truth and threatened to call ACS if I didn't and my kids are everything to me. I was scared because my kids are my everything and I would go crazy if they were taken away from me. They went to arrest him and once again, he played the role of a nice guy after and his family wanted me to drop the charges too. Also, the police officers told me that they thought I was lying and were trying to get me to drop the charges.

Participant 002 stated,

> Yes, my doctor had and I did tell her but she didn't do anything. She referred me for therapy and didn't do anything for the kids. The tricky part is that well she

> was like an old fashioned doctor and she told me to tell him he needed to help with the baby because that was more my complaint. The trick to that is that people don't really want to say these things because sometimes it puts you more in a jam. There's not that much confidence in the world that you're going to go tell your doctor unless you're ready to move past it and be done, get out of the relationship. If you didn't mentally check out of the relationship you are going to lie. Because, you're already dealing with an abusive relationship and now you got people questioning you about your kids or worst case scenario taking your kids.

Participant 001 noted:

> Yes, I've been screened and was honest. My old town only has one shelter. So, I had to leave that town and get help. When I got screened they would look at me like it was my fault and like I was wrong. They like to guilt you like you're the fault of it.

Participant 009 verbalized:

> I was screened when I was with my older kid's father who was abusive. He punched me in my mouth, stabbed me in the leg with a screwdriver, and did other things to me. In the hospital they asked me but I told them that it wasn't domestic violence. Now, I'm open and wouldn't be afraid to say that I'm a victim.

Theme 7: Once separated, most found themselves isolated and living in shelters which were not conducive to rearing their children.

Postseparation codes, which were derived from the detailed descriptions provided by the participants, included feeling isolated, living in shelters and the conditions they

encountered in the shelters. For victims of IPV, separation is a process which increases their risks for femicide by nine-fold in cohabitating couples (Campbell et al., 2003; Centre for Research & Education on Violence against Women & Children, 2010). Most (*n = 8*) of the participants experienced having to go into hiding to separate from their abusers. They uprooted their lives, and the few friends and family members who were their main source of support were left behind. Participant 001 described how she moved over 300 miles away from her hometown and lived in various shelters during a six-month timeframe. Participant 001 stated:

> My older son wanted to throw himself out the window when we were in the shelter and we started counseling and were given an apartment quick. When we were in the shelter they kept moving us. They kept moving us from shelter to shelter. Like, one week we would be here in the Bronx, then we went to Far Rockaway, and then they threw us to Brooklyn. We were never stable and I didn't have medications for myself or my son. It was very hard. The whole transaction of leaving, going to a shelter and being moved around was a big change for him and it affected his schooling. My kids have gone to many schools in the past year so they haven't been stable. We went from Queens to Brooklyn and now they're in school in the Bronx.

Participant 004 described how the shelters were unsafe, she stated:

> When we went to the shelter, it was the first time and they didn't like it, they were depressed. We were all depressed, we were not happy that's why I took that apartment when it became available even though it was on the sixth floor with no

> elevator and it's hurting my leg and my asthma but because I didn't want to see my children depressed anymore or me being depressed I just took it to get out of the shelter. I was in the shelter for two months with my kids. I went all over the place, I don't know how people could be in the shelter for two to three years, five years where there's drugs, nastiness, rats, and roaches.

Participant 003 also verbalized:

> In the shelter, it was the first time I had both my kids without help and I was stressed. Basically, I taught myself how to cook and take care of my kids alone. I had anxiety after anxiety attack dealing with the school and everything else alone. And, with my son's outbursts and he (the ex-partner) was still trying to communicate and still trying to control. At the shelter, the kids called it the spooky house. They were both afraid of being there. My daughter started seeing things in my son when he was sleeping. I put water under the bed because I had been taught by my aunt that it helps a person sleep. It felt like there was a black cloud in the shelter because lots of things had happened there. The workers were having relations with the clients, fights and it was too much going on in there. It's still going on and nobody knows. My son had a rusty bed and they had to give him a shot because he cut himself while playing around. I found that he started cursing a lot, he didn't want to go to school, he had a fight on the bus and he didn't want to get off the bus to go in the shelter.

Thus, moving into unsafe shelter environments appeared to have contributed to the instability of most of the participants and their children. There was one discrepant

case noted where the mother stated she and her children had been living in and out of shelters for five years.

Theme 8: For some mothers, the perpetrators had discovered where they lived and had threatened them.

Being in hiding and living in fear were codes that were derived during the interviews particularly among participants who had seen or were aware that their ex-perpetrators had discovered where they lived. When asked about their roles in the immediate family five of the participants verbalized that they continued to live in hiding and feared retaliation by their ex-partners. Participant 001 said,

> I'm living in the Bronx because I had to get away. Right now? My role right now is fearful because he's trying to locate me again and I try to stay home and not go out, and I can't let my kids go out. He's contacted me and said that he knows the police is after him and that he's not going to stay still until he found me, he'd rather see me dead than with anybody else. I just want to go back to normal where we don't have to hide anymore, start a new life. Until mommy doesn't get her safety, we can't do anything. We do go out but I'm shaking, and it's not fair to them.

Participant 006 noted that,

> I was starting to settle in and then recently I saw him two blocks away from where I'm living. I was approved for a transfer but can't find an apartment. I'm scared, and I have a niece who stays with me sometimes to protect me from him, but it's not easy because there are times when my stress levels are high, or I see

> something on television which is a trigger that makes me cry. Sometimes I just don't have the energy to go out or do anything. I don't feel safe on the street and rather be cautious and just stay home. Not too long ago someone was trying to open my door at home, and I called the police. It turned out to be a drunk, but the police didn't arrive for over an hour. If it had been him, I would've been dead by the time the police arrived.

Participant 007 described how she was living in hiding and fearful, she stated,

> He threatened to kill me and had told the police that even from jail he can still get me killed. I finally left and took him to court, and he went to jail for three years. There's very few people who know where I live for my own safety and that of my child. I'm scared in our apartment, can't sleep and have multiple locks on the door. My bed faces the entrance to the door. I know that he knows where we live because his mother helped me move two years ago. He hasn't come, but I know she must have told him.

Participant 004 stated,

> Now, my ex-partner found out where I'm living from his cousin, and that's why I'm dying to move out of there. My daughter's friend knew his niece, and he's been trying to knock down my door, and I told them I need to move, but it's like they don't care either. When somebody ring's my doorbell, I don't even feel like answering because once my kids are home, I don't need to answer that doorbell. If you're not calling to tell me you're coming over I'm not so I don't answer. This has been going on since last year; I've called the police.

Participant 009 had stated that "last month he threatened to kill me again and I went back to court and got another order of protection." She did not get into details as to how he had contacted her.

Theme 9: Many of the mothers had experienced trauma and parental substance abuse during their childhood.

In ascertaining information about the mother's childhood experiences coded data included abuse in prior intimate relationships, IPV exposure as children, parental substance abuse, and child abuse. Traumatic experiences during childhood are a risk factor for victimization in adulthood (WHO, 2014). Adverse childhood experiences can include but aren't limited to, being a victim of abuse and neglect, family dysfunction including parental drug use and to being exposed to various types of violence (Felitti et al., 1998). The participants were asked about the cultural or personal values that they felt may have influenced them, their family or their relationships. Seven of the nine participants (78%) reported some type of adverse childhood experience that they felt had influenced their choices in life which included IPV exposure and other types of traumatic experiences as children. For example, 67% ($n = 6$) of the participants had been exposed to IPV among their parents when they were children. Participant 001 discussed that her mother "tried to give me advice because my father was abusive and she saw it in my husband." Participant 002 stated that "As a kid, my dad was verbally abusive and I'm the second youngest of seven. I don't remember my dad getting physical, but I've heard from my sibling's that he did physically abuse my mother." Participant 004 stated:

> I grew up in a verbally, mentally and physically abusive home with my parents and my children didn't see as much as I did. I saw my mom with black eyes and other bruises, everything and it stopped once we grew up.

Participant 009 noted,

> My mother was abused by my father, and then when she was in another relationship, it was abusive too. I wasn't angry at my mom. I would basically defend her, but I feel mad because I'm living the same thing she did. I know my daughters will suffer the same things too because it runs in the family.

In addition to having been exposed to IPV, 83% of them reported also being abused when they were children. The co-occurrence of child maltreatment and neglect with IPV is well documented in the literature (Felitti et al., 1998; Goddard & Bedi, 2010; WHO, 2014). Participant 002 described how having been shunned by her family because she was sexually abused as a teenager by someone in her community changed her life forever. She stated,

> From when I got raped I felt that change because I was a different person before that happened to me. So, when I say walk the straight line that was the person before I got raped. I was good at everything-talented in school I was like that good kid, and that just changed me completely. So, yeah, I felt like I was supposed to be that person that walked the straight line. Sometimes they can get through certain things and still come out better even though you went through something and I always felt like I kind of always asked why me. It kind of feels like the person took you with them and left this totally different person frozen in

> that time. I wish that never happened because I know that my life would have been different. It still happened to me, and I know I would've been a different person because of the drive I had in me.

Participant 007 stated that "I was abused when I was seven by my uncle and he went to jail." She tearfully verbalized that she told her mother who took action against the molester. Participant 008 who was physically abused by her grandmother and sexually abused by two family members described that she never told anyone but her sister suspected because she wasn't herself. She stated,

> As a child, I was raped twice by family members so when I returned to Puerto Rico, I felt alone and slept on the streets. I had no one who was willing to help me. My mother was married three times, my dad died when I was 8, and one of my stepfathers abused me. My uncle and my mother's husband are family but they don't have the right to do what they did to me which I still remember it like it was yesterday and something I have never recuperated from. My sister knows because she noticed I was different and no longer the life of the party. I was also abused by my grandmother (father's mother) because she didn't like my mother and I looked like her.

Additionally, parental substance abuse appeared to be a commonality among 56% (n=5) of the participants during their childhood. Participant 007 recalled:

> My dad was always involved with drugs and alcohol his whole life so being a female I kind of led my life like a male in the streets, trying to find somewhere to

> rest my head safe, trying to figure out what I'm going to eat and shower when I was 12-13 years old.

Participant 005 verbalized,

> At one point my mother was addicted to crack, and that's all she cared about. It's like when you're in that world there's a cloud over you, and I was living with my father. Sometimes she would pick me up, and sometimes she wouldn't, and I didn't know what she was doing at the moment. I was about eight years old, and I lived with my dad for two years. I lived with different family members because my mom and dad divorced and had their own families.

Participant 001 whose father was an alcoholic and lived in Puerto Rico said "my mom would send me to him every summer until I was nine years old. When I was nine years old, he came home drunk, and I was there with my grandmother, and he beat me with a belt so hard".

Theme 10: Many of the mothers had family responsibilities at a young age, became pregnant during their teenage years and dropped out of school.

Coded interview data for theme 10 included family obligations at a young age, teenage pregnancies, and education demographic data. It's not unusual that children who grow up in dysfunctional environments take on adult roles and sometimes act out (Felitti et al., 1998). Three of the participants in this study took on adult roles and described how they acted out. Participant 007 stated:

> Once my dad left I was twelve, and it was different since he wasn't in the house. I started acting out. I felt like no one could tell me anything since I was a teenager

> and had been so caved in dealing with everything in the house. So, when they separated, I just ran loose.

Participant 003 stated that her mother worked and she was responsible for taking care of the house and her sister. She noted,

> The problem with that was that my father raised me at the time, at the age of 16, I was working in a school teaching dance. So, me working and having responsibilities very early cleaning, cooking, doing everything a normal housewife should do because my mom was always working at the time. So, I was doing stuff that my mom should've been doing at home. I was taking care of my sister, buying myself clothes, food for my sister and me.

Additionally, seven of the nine participants (78%) dropped out of school and six of them had teenage pregnancies. Participant 007 noted "I had been with my daughter's father since elementary school…he abused me before, during and after I was pregnant." When asked about her education, Participant 001 stated she dropped out because "I needed to take care of my oldest son because I was pregnant in the ninth grade." Participant 004, who had a ninth grade education, stated "I was like 16 when I got pregnant with my oldest daughter." Participant 003 noted that "they were only offering me night classes and my father didn't want me to do night classes so I stopped going to school in 12th grade."

Theme 11: All of the mothers felt that family unity was important to them.

Coded and categorized data for theme 11 consisted of cultural values and beliefs as described by the participants which they grew up with and felt influenced their lives. Collectivism and patriarchy are deeply embedded values in the Puerto Rican culture

(Ghali, 1982; Mogro-Wilson, 2013). Familism encompasses close ties to near and distant relatives which form a cohesive network of support (Ghali, 1982; Mogro-Wilson, 2013). Additionally, the value system of familism, in the Puerto Rican culture, governs an individual's conduct and responsibilities in the family and in public (Zayas & Palleja, 1988). The socially covert or overt ascribed roles are protecting, advising and assisting other family members (Umaña-Taylor & Yazedjian, 2006; Zayas & Palleja, 1988). All of the participants identified themselves as Puerto Rican even though six of them were born in the United States. The interviewees were asked about the cultural values that were important to them as a Puerto Rican woman. Participant 001 noted "Taking care of my kids, everything, I have to protect them I am the only thing they have." Participant 002 stated "Family get-togethers, the food, sharing, it was like we were very rich in culture and to enjoy life." Participant 003 discussed:

> Prayer is one of my family's values that was passed down to me, cooking, and being together as a family. Communication is also a big deal within a family and being able to talk things out together. Parties and the dances are my favorites, I knew them all and was taught by my dad. Knowing the language was something I was taught early on, and I speak Spanish fluently.

Participant 004 noted:

> For me family means that a family should stick together, be together, and help one another to have a means. The family is a very important factor in my point of view because if you're not united to your family, this is how you look for other means and ways of getting the help that you need. So if you don't find it in the

> family, then you find it in a friend, but sometimes that friend doesn't help you the way a family will. So family for me is very important to be united.

Despite all of the participants identifying communication and unity as important cultural values, 56% (*n = 5*) of them were estranged from their families. Participant 009 noted that "I have two sisters, but I haven't seen them since my mother passed away." She went on to discuss that she was very close to her mother and that when she relocated from upstate New York she and her children "…stayed with my sister for a couple of days and then she threw my kids and me out." Participant 007 stated, "I don't really have a relationship with my family." However, during the interview, she said that the reason she didn't have a relationship with her family was that she wanted to protect them from retaliation from her abuser. The cultural value of protecting relatives resonated with Participant 001 who discussed how she didn't tell her stepfather about the IPV because he was over protective and things would have gotten worse in her relationship.

Out of the nine participants, two of them discussed that staying with their family was not an option. For example, when Participant 005 found herself homeless with her five kids, she explained:

> I was going to live with my sister, but I don't want to deal with people's rules so I'd rather just go to the shelter and get my own place so, that way I don't have to deal with nobody. I come, and I go as I please and do what I want, you know. I wanted my kids to have their own space too.

Two of the participants who had lived in Puerto Rico with their family felt that things were different the United States. Participant 006 said "I believe in having a united

family, and that's not the case in this country. I feel very alone, and it's like nobody cares." Individualism and independence which are cultural expectations in America may contradict the values of familism for Puerto Ricans (Ghali, 1982).

Theme 12: Many of the mothers were warned by their family members about their ex-partner.

Coded and categorized data for theme 12 was derived from the values described by the participants which included family member attempts of assisting, warning and protecting them. It's also important to note that family members tried to assist and warn the participants about their abusers. Participant 001 stated that her mother provided "advice because my father was abusive and she saw it in my husband. I never listened because when you're in love, you're blind." In contrast, participant 004 became angry when her family tried to warn her about her abusive relationship. She stated,

> My family was against him because they found out what was going on with the abuse. When they tried to get involved, I didn't let them because it was my life, not yours. They didn't want me to be involved with anyone just be by myself, and I don't think it's fair. You cannot tell me how to live my life because I didn't tell you not to be with my father and he was abusive. I never got involved with their life, but when they got involved, it made it worse, so I just stayed away from them.

Theme 13: All stayed in the relationship because they wanted to keep the family unit together.

Data was coded and categorized for theme 13 related to the reasons the participants provided when they described their values and lived experiences for staying in the relationship. In addition to familism, marianismo which refers to the traditional cultural perspective of females treating others with kindness, sympathy, and humility also had a strong influence on tolerating the IPV, help-seeking and parenting behaviors (Dietrich & Schuett, 2013; Mogro-Wilson, 2013; White & Satyen, 2015) among all the participants. In contrast to what is described as the honor code (Dietrich & Schuett, 2013), all of the participants had separated from the perpetrator and sought help for themselves and their children. However, as is common with the value of familism and marianismo all of the participants described how they tolerated the IPV because they wanted their children to grow up in a two-parent household. Participant 001 discussed that she had made several attempts to leave the perpetrator but returned because of her son. She stated,

> I always have the saying you will stay with somebody and do what is best for your kids, and I have a son who has autism and he's really attached to his father. He tried to hurt himself a couple of times when I tried to get away from the relationship so for his being; I stuck with it.

Participant 004 noted, "He came in the picture and I thought he was going to give them at least a father example, but he didn't." Participant 003 said:

> All my daughter and I knew was him because I'd been with him forever and I didn't know how to leave the situation. I was focused on my daughter having a happy home, him changing and her growing up with both parents.

Theme 14: The majority of mother's left because they feared for their lives or because of the effects witnessing IPV had on their children.

The coded data for theme 14 included categories of the lethality of an abusive episode and their children as reasons for living and leaving. Regardless of all the participant's desires to keep the family unit together, they separated and sought help when they realized the potential lethality of the IPV and the effects it was having on their kids. Participant 007 stated, "As time went by my daughter was seeing things that she shouldn't have." Participant 001 tearfully described the last incident which caused her to flee, she stated,

> The last thing he tied me up in a chair and tied my kids up saying that he was going to kill us. I don't know how I got out of that chair, but I did. I ended up hitting him in the head with a pot, left my kids there because I know he wasn't going to hurt my kids and came back with the police, but he was gone. At that point, I knew I had to leave.

Theme 15: All of the mother's blamed themselves for their children's exposure to IPV.

This theme was categorized when the mothers discussed self-blame for their children's exposure. When asked about how their child's reactions to the incidents affected them, Participant 001 stated, "It hurts me and kills me inside to see them like

that. No mother wants to see their child like that, and I blame myself. If I would have gotten out sooner, none of this would have happened." Participant 003 noted "It hurts me a lot. I feel like it's my fault. I feel so bad that I put my kids through this, but I didn't know how they would be affected so bad." Participant 003 stated, "It hurts me a lot. I feel like it's my fault. I feel so bad that I put my kids through this but I didn't know how they would be affected so badly." Participant 004 verbalized:

> Now that I'm not with him it's like what was I thinking? You know, sometimes I blame myself because I could've avoided all of this from the beginning when it first started but I don't know that was just life.

One participants (009) discussed how she tries to understand how the IPV has affected the children and doesn't hold a grudge about their angry reactions towards her. She stated, "In general, I feel bad but if the kids are angry I don't mind because they're right and I understand".

Participant 006 felt that her daughter was too young when the IPV was occurring.

Theme 16: All of the mothers were committed to protecting and making their children a priority.

Theme 16 was derived from coded and categorized data which included their caretaking role of protecting and making amends. All of the participant's described their role as being the primary caretaker of their children, protecting and making them their top priority. Participant 002 said, "My role is to take in and endure or pay for the mistakes I have done as long as that means they come out of it." Participant 003 described her role as "I am the protector. It's my job to keep my children safe and look out for them

especially after everything that has happened." Participant 005 described that "Right now none of the kids are living with me. I'm fighting for them to get them back." Participant 007 stated, "After everything that has happened I do look at things differently especially in terms of my family which is very important to me. My daughter is number one to me." Participant 008 stated,

> I feel that my role is to look for help because the kids depend on me. I'm …protective of them because we live in a bad neighborhood where there are shootings and lots of drugs. If something happened to any of my kid's I don't think I would survive.

Additionally, the mothers who participated in this study discussed situations where they felt that they had to protect their children. Participant 007 noted with regards to her daughter's relationship with her ex-partner "If I can help it, I will keep her away from him and protect her." Participant 003 discussed how she protects her children from witnessing IPV among other family members, she stated,

> I have a brother who lives with my mother, and he's abusive to his wife, so they don't like him or want to be over there. They love my mother and the rest of my family. Instead of having them visit my mother, my mom comes to see them at my house.

Theme 17: Several of the mothers taught their children life skills.

Theme 17 codes and categories were derived from teaching practical skills. As primary caregivers to their children, five of the participants expressed how they took

actions to teach their children some life skills based on their own lived experiences. Participant 007, who suffered sexual abuse as a child by her uncle, stated:

> I've trained her before she could walk in that way because I was never allowed to sit on anyone's lap and was not friendly with just anybody which is what my dad taught me. Those are things that I passed on to her and let her know if XYZ starts to happen she knows. She knows there are bad people in this world and I have taught her how to dial 911.

Participant 008 stated that with regards to the abuse her son witnessed, "I tell him to forgive him even though he isn't with him." Participant 003, whose kids witnessed the IPV, stated that her son, "He used to hit my daughter back when they fought, and now he doesn't do that anymore since I had a talk with him about hitting girls." Participant 004 stated:

> I taught them how to clean, cook, wash clothes, everything. If they meet a man or a woman, especially my grandson, who doesn't know how to do it he knows how to do everything. He won't die of hunger, he will have clean clothes and he will have food in the house and he won't die of starvation because he knows how to do all that.

Theme 18: All of the mothers discussed goals for themselves or their children to have a better life.

The codes for theme 18 were derived from the mother's help-seeking behaviors, hope, and caretaking. Despite the setbacks they encountered when they had returned to their perpetrators, it was enlightening to hear all of the women talk about their future

hopes and aspirations for themselves as well as for their children. Participant 007 stated "She loves school and wants to be a teacher. I encourage her to do whatever she wants to do as long as she stays in school. I want her to be someone." Participant 001 discussed:

> I never finished school, but I want them to go to college and get an education. I want to get my GED and started looking into it, but now with all this, I just need to wait. I want to go for nursing too. That was my mom's dream, and she never got to fulfill her dream, and I want to do it for her. Those are my goals as soon as things get better.

Participant 009 stated "my goal is to complete the classes I need to get my kids back. I keep a journal that is my life and want to write a book about my experiences."

Theme 19: Several of the mothers pass on Puerto Rican values and traditions with their children.

Also, regarding culture-family values, traditions were also categorized and coded as discussed by many of the participants. All of the participants happily recalled traditions such as big celebrations, music, dancing, respect, and carrying on the language. Participant 008, who had lived in Puerto Rico with her children, stated,

> When I see festivals, it makes me sad and reminds me of all of the beautiful things from Puerto Rico. My kids were born there, and I always remember the wonderful celebrations and traditions of Christmas, the food and the traditions that are ingrained in us and our culture. It brings me happiness, and it influences the kids. My daughter knows how to dance all of the Spanish dances, and I taught

> her. I loved dancing with them since they were little and saw them enjoy everything about the culture.

Participant 003 told me, as she smiled, that:

> Parties and the dances are my favorites, I know them all and was taught by my dad. Knowing the language was something I was taught early on, and I speak Spanish fluently. My dad wouldn't answer me if I spoke to him in English. I tried to pass down the Spanish to my kids, but it's hard for my son because he has autism. My daughter speaks it with my parents and my son tries. For me, we all make sure to get together as a family, and we even have the instruments that are part of our own music. We love the old songs and add our own beat to it. The kids love the instruments and my daughter and son both love to dance.

Participant 004 stated, "I just give them the values that I was given that was my Puerto Rican culture teach my children manners, discipline, education, and independence." Participant 003 stated, "She shares, has manners, is respectful, and is very polite."

Theme 20: All of the mother's had one or more sources of external support.

The external support systems of the participants included coding and categorizing them using counseling, friends, family members, the community, their faith, and the system. All of them reported having some involvement with counseling either for themselves, their children or both post separation. Participant 004 stated,

> I went out there to seek counseling because I had problems in my life and I can't solve them, or I have nobody to speak to why should I hold this in my heart and in my mind? It's going to get me sick, so I find me somebody that I can speak out.

Participant 006 reported going to counseling sessions twice a week. Participant 009 stated,

> I go to therapy, and I like him, but he's going to graduate, and I'm going to have to see someone else.

Unfortunately, one of the participants had negative counseling experiences. Participant 003 stated,

> For me, at the shelter, I stayed to myself. I found out that people knew my story and this was because one of the counselors at the shelter was telling everyone about my business. I sought counseling outside of the shelter, and I'm still seeing my therapist.

When I asked the participants about their friends or family members as social supports, there were mixed emotions. Participant 001, who had been very close to her mother, cried and stated,

> My mom is really sick, and that's what hurts me I have nobody here (crying). I talk to my mom every day. I try to have contact with her, but I try to not have contact too much because of him.

Despite having left the relationship, she also has no contact with her siblings because she suspected that her brother had given her ex-husband her contact information, so she verbalized "I'm not going to expose myself to them until I feel safe again." Participant 005 stated, as she smiled, "Sometimes I talk to my friends, but I really don't hang out that much. I talk to my mother that's basically it; my mother and my boyfriend. We've been together for four years." Participant 007 stated, "Now, my mother and I have

a good relationship. I have legal documents which give my mother full custody if something were to happen to me." Participant 002 discussed how a friend supported her throughout the IPV when she separated and afterward. She noted,

> My friend, he gave me his credit card and told me to buy what I needed for the kids which were a blessing of a new beginning of me finding myself again, and he's still in our lives. He's supportive financially and morally, and I can tell him anything.

Participant 006 verbalized "I have a boyfriend with benefits who helps me with my daughter. Sometimes he's a little jealous, but he's not aggressive and has been very supportive and has stood by my side during the most difficult times. We've been together about three and a half years."

With regards to the community as a resource for social support, Participant 001 stated. "The community where I'm at now everybody knows me, but I really don't have friends. They actually know me because of my kids, I really don't associate with anybody, but they watch out for my kids."

Participant 007 verbalized,

> I do go to church more now than ever. The church I go to are mostly American's and it's like a whole different environment of very loving people. I find that every little bad thing that happens, I turn to the heavenly father or the gospel just to bring me back to reality. It's like a meditating thing that calms me down. I have a great relationship with all of my daughter's teachers. I'm involved in school activities and feel that they watch out for me since they know my situation.

Participant 006 stated, “In my community, I find that people will step over your body if you’re dead on the street, so I don’t really have friends in the community.” Perhaps she felt this way because of a lack of acculturation since she had been in the United States for five years.

Theme 21: The majority of the mother’s had challenges navigating the system.

When categorizing data on social supports, I coded both negative and positive responses. When I inquired about the system, there were primarily negative (n=7) responses regarding their support. For the most part, immediately post-separation all of the participants felt that navigating the system was a challenge. Participant 001 stated,

> Women who go through domestic violence are treated differently; like it's, they’re the fault. Where I go to get help, it’s like you’re the fault and I’m so done. It’s not that I’m giving up it’s that it hurts because I’m not doing it for me it’s for the kids and to protect us. The system isn’t easy, especially in court. The judge has told me to dismiss the case, and I said that’s why a lot of women get killed because they listen to you and dismiss it.

Participant 008 said,

> The system is unfair to Puerto Rican’s, and they don’t understand. I came here and stayed in a shelter, and that wasn’t easy. They gave me an apartment, and I lost it because I couldn’t work or pay the bills, so I had to return to a shelter.

Theme 22: Many of the mothers described having challenges with trusting others.

Data on support networks was also categorized regarding trust and meeting new people post-separation. It appeared that despite having left the abusive relationship, there

continued to be long lasting effects related to trust or fear which resulted in isolation. Participant 007 stated,

> I really don't have friends because I don't want to place any problems on them. Once in a while, I reach out to friends, but it's not like it was in the past. I have a cousin whom I'm close to, but I'm afraid to get too close.

Participant 009 stated "I don't have friends. I stay to myself." Participant 008, who is now married, stated:

> For a long time, I didn't want to be near a man even though he wasn't the one who abused me and it wasn't his fault. I was afraid of being attacked and would go to sleep and hear his voice screaming at me, and that had a great effect on me. I have a good partner now, and sometimes I feel hurt because he's not at fault for what I've been through and it took me eight years to trust a man.

Also, issues associated with trust influenced seven of the participants coping capabilities. Participant 004 stated,

> You know well I'm a woman I have needs, and I feel lonely, and it's true I feel lonely and sometimes men start good, and at the end, I don't know what happened I've been having bad luck. I find a good man all of a sudden he messes up.

Participant 007 stated "I still have a wall up which is like a lifetime shield because of what I've been through."

Theme 23: A few mothers learned positive lessons from the system.

The system was explored as a supportive network and categorized accordingly for both negative and positive responses. Two of the participants learned about the system

and used the information to advocate for their rights and those of their children. Participant 002 noted,

> In the shelter, there was a lot of support for myself and my daughter. They did activities with her, and I think it really helped her to keep her mind busy and work things out through art and play therapy. Even when we were moved from one shelter to another, I kept her in the same school zone so she wouldn't have to start all over. I felt that transitioning from one shelter to another was bad enough. Throughout the craziness, I had to keep that stability as a parent, and I knew I had the right and advocated for them.

Participant 007 also discussed how she learned about her rights through the system. She stated,

> Going through the system, the classes that I would go to and hearing pieces of certain people's situations, dealing with the caseworkers taught me so much. That's why I knew that I could take his rights away, get an order of protection, keep her from him and not allow him to see her. I have the right to do things the legal way, so it taught me a lot even with his mom who threatened me for years about taking me to court.

Also, despite the challenges they endured while living in the shelters, three of the participants discussed that they were grateful for certain things that occurred while they were there. Participant 003 stated,

> I had a caring caseworker who was different and trustworthy than anybody else there I knew. I cried to her about the situation. My son had gotten hit with a

> seatbelt on the bus, and he was just a different kid when we were there. She put me in touch with an autism advocate, and we changed his school, and I love the school. He's changed and isn't the troubled kid anymore.

Participant 002 stated,

> In the shelter, there was a lot of support for myself and my daughter. They did activities with her, and I think it really helped her to keep her mind busy and work things out through art and play therapy.

Theme 24: Despite separation, many of the mothers had continued emotional, mental health and physical challenges.

Theme 24 data was related to codes which reflected maternal illnesses and emotions including stress. The challenges of the IPV, separation, and uprooting their lives was incredibly taxing on all the participants. Many authors have noted that IPV has long lasting injurious effects that continue post separation (Alejo, 2014; Karakurt, Smith, & Whiting, 2014; Letourneau et al., 2013). The symptomatology associated with IPV may manifest in the form of physical or psychological ailments including phobias (Black, 2011; Karakurt et al., 2014). Seven of the nine participants reported that they had health issues which included, but weren't limited to, anxiety, depression, chronic pain, hypertension, and fibromyalgia. Participant 006 stated, "I've been having a lot of medical problems and have had multiple abdominal surgeries, so life hasn't been easy." Participant 004 noted "I have fibromyalgia and depression, but the medication doesn't work when I'm really stressed out or worried." Participant 001 stated "I can't sleep so

now they got me on really strong medications to not wake up at night, but it's not helping, so I'm going back to the doctor." Participant 006 stated,

> My medical problems include anxiety, depression, insomnia, and I hear voices. Those are the mental problems that I take medications for. Physically, my right shoulder and right knee are painful, and I'm getting a hernia in my stomach again. The hearing of voices started about three years ago, and I see a psychiatrist twice a week. The voices are bad, and they tell me to kill myself.

In addition to their diagnosed illnesses, the participants discussed a range of emotions which included fear, sadness, stress, shame, and frustration. Participant 007 described her feelings of fear and sadness, she stated,

> I'm sad that he doesn't make his daughter a priority and is now in and out of jail. I don't speak badly to my daughter about her father, and she has pictures of him in her room. I'm scared in our apartment, can't sleep and have multiple locks on the door. Even if he didn't know, I still have a wall up which is like a lifetime shield because of what I've been through. My daughter doesn't appear to be afraid, and she doesn't notice things too much.

Feeling overwhelmed and stress was evident in participant 009 whose children had been in foster care for 7 months. She stated that the first foster caregiver didn't take care of her children. She noted,

> The first foster parent they had was harming all of my children. The foster parent used to keep my son out in the street. The foster parent would allow a 20-year old foster kid to watch my daughter's while she was out. My kids would only be

> allowed to bath once a week and when I visited them they smelled badly. She would lock them in the room all day on weekends.

She described having to go to court and petition the judge to remove them from that environment and that they're now in a new environment, she stated:

> I think that the new foster parent has really helped them along with the counseling. Now, when my son and 11-year old argue the foster parent tries to calm them down. She encourages them to talk to each other without yelling. She's able to calm them down and stop them from cursing at each other. They also have rules they have to follow and they know what they can and can't get away with.

Participant 005, whose children were also in foster care stated: "I get overwhelmed with all five of them, and it's a lot for one person." Participant 008 said,

> I run back and forth trying to do it all, and it's very stressful. I feel that here since the domestic violence was in Puerto Rico, they forget. It shouldn't matter how long ago the violence took place or where the victims need help. I've been here since 2009, and I just feel like I haven't made much progress.

Participant 003 admitted to having another partner outside of the IPV relationship; she expressed shame when she stated,

> He didn't want me on social media, and I suspected he was doing something that he didn't want me to catch him so I said to myself two can play the same game. But, at the end of the day when you do get that revenge, you feel nasty about doing it. I did it, I went behind his back, and I felt dirty about myself, and my

> womanhood went from high to low. Revenge is not something a woman should do when a man cheats. At the moment it felt okay, but afterward, I cried.

Theme 25: Several of the mothers had developed positive coping mechanisms.

The category of coping mechanisms was coded based on feedback received from the mothers related to stress relieving tactics used. All nine of the participants described a variety of coping mechanisms. Seven of them found solace in being with their kids, friends or family members. Participant 007 explained how her trips to Florida have helped her, she stated,

> I go and visit my mother in Florida for the summer and again during Christmas, and then I come back. I love it; it gives me peace of mind, and I have help with my daughter over there. It gives me time to take a walk, sit in the backyard, just time for me alone for a second. I know that my daughter is in good hands and nobody knows me over there, so it's like a whole other world.

Two of them described actions they took which were helpful in decreasing their anxiety when they felt overwhelmed. For example, participant 006 noted, "I keep the television on all day and night because it helps me not hear them and calms me down." Participant 003 stated:

> Whenever I get a little stressed, I tell the kids I have to go to the bathroom and there I just breathe and relax. I tell myself it's going to be okay, and then I come out. So, the kids know when I go to the bathroom mommy needs that time alone.

Research Question 2 Themes

What are the perceptions of Puerto Rican mothers who are victims of IPV on how exposure to IPV has influenced their children aged six to 11 years?

Theme 26: Many of the children were exposed to IPV in utero and were exposed at an early age.

The coded data for theme 26 was categorized by onset and types of exposure based on the mother's perceptions. Among the biological mothers (*n = 8*), most (*n = 6*) reported that they were pregnant and that a total of seven children were exposed to IPV in utero. They reported that their children were exposed to multiple episodes of verbal (*n = 9*) and physical (*n = 8*) abuse. Two of the mothers reported having been raped but that their children had not been witnesses to the sexual abuse. When asked about child exposure, Participant 001 stated,

> my son's pregnancy happened because he raped me. I was pregnant with twins, and he was abusing me the entire time, and one died while it was inside of me. I gave it a burial because it died when I was six months pregnant.

Participant 008 described that her ex-partner was abusive during both her pregnancies and noted,

> My daughter was born prematurely and was underweight. He would beat me when I was pregnant with her badly by punching me in the stomach because he didn't want me to have her. She was very sick when she was born because he ruptured my placenta and she was in intensive care.

When I asked the participants about their child's exposures, eight stated that their children had been direct witnesses to multiple forms of IPV throughout their lifetimes (Figure 1). Participant 009 said, "The kids heard and saw everything except the rapes" and Participant 001 also noted, "The last thing he tied me up in a chair and tied my kids up saying that he was going to kill us. My kids have seen it all." Participant 002 stated,

> One situation that really screams out at me is when my 10-year-old daughter's dad was choking me on the sofa in front of her. He was choking me to the point where I felt like I was going to pass out and I couldn't breathe. I just couldn't imagine him, god forbid, killing me in front of my daughter.

Theme 27: Most of the mother's described that their children were old enough to understand.

Theme 27 coded data was derived from the category of age of the child's age of onset of IPV exposure. The vast majority (n=7) felt that their children were old enough to understand. Participant 002 stated "She was already at the age of kindergarten. I still remember stuff from kindergarten so how could she not remember?"

In contrast, participant 006 described that she was depressed, verbally abused during her pregnancy and physically abused afterward, but when asked about her daughter's exposure she stated: "My daughter was young and I don't think she remembers anything." Participant 003 stated,

> My son was with my mother most of the time, so he didn't see much. I think he heard me talking about it…may have learned of things from my daughter… I

know he's seen us argue especially at night when my daughter's father would want me to cook him food at three in the morning.

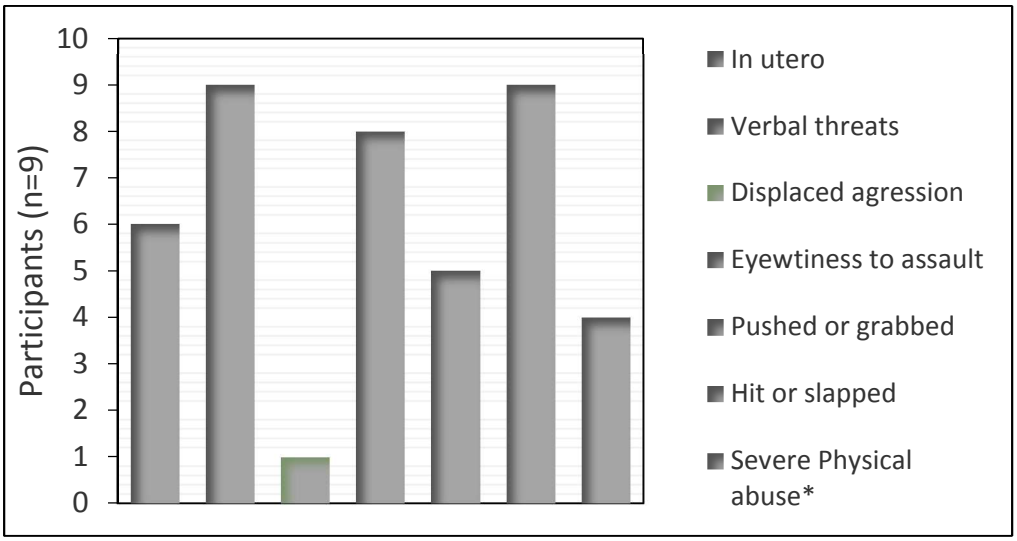

Figure 1. Overlapping types of child IPV exposure

* Severe physical abuse may include acts of pulling hair, kicking, choking, being burned, beaten, or the use of a gun or a knife (CDC, 2017)

Theme 28: Fear, anger, internalizing and externalizing behaviors were common in the children.

The coded data for theme 28 was categorized based on the mother's feedback of their children's reactions immediately, during and after exposure to IPV which included a myriad of overlapping responses such as anger, fear and behaviors associated with externalizing and internalizing. The mothers of the IPV-exposed children aged 6 to 11 years, discussed a range of reactions immediately, during and after the IPV incidents. Similar to the multiple types of IPV exposure, the mothers described a multitude of responses immediately, during and after the incidents. The mothers reported child

responses which included fear, intervening, shock, crying, hiding, and screaming or yelling (Figure 2). Participant 003 stated,

> Both of them were afraid I was going to get killed because they had heard him say that. My daughter would look at me and then would run and hung me. She would whisper that everything would be okay, but I could feel her shaking and her heart beating quickly. My son would hide and not get involved the times he was there when it happened. There were a few times when he (my son) would have outbursts and start banging his head on the wall. My daughter and son tend to just stare into space sometimes, and they do ask questions. I guess they're trying to understand how someone could do the things my ex-partner did to me.

Participant 007 stated,

> She looks at him with fear in her eyes, and she grabs my hand tighter. Afterward, she has said things like “daddy gives me a headache.” She has asked me why her daddy is always screaming at me and ruining mother daughter day.

Participant 001 stated,

> They would scream and cry scared. They would try to hit him and protect me but he would always yell at them and hit them, and they would stand in the corner and cry. After, they would be shaking, crying and get really nervous.

Participant 002 stated,

> The only thing I can say was that I think she was having nightmares. She would wake up startled or in the night jump up. This was while we were living with her dad and after when we were in the shelter. It took like a good year that I noticed

> she was having those issues. I don't know what this was about, but of course, all of this was taking place, so it had to stem from that. Now, a year after, she sleeps fine and sometimes I have to wake her up.

Participant 006, who had reported that her daughter was too young stated that her daughter "…was born premature and didn't walk or talk while we were living in Puerto Rico". However, her daughter was born with macrocephaly which is associated with developmental delays (Vertinsky & Barnes, 2007). Additionally, developmental delays in young children have also been statistically significantly associated with delays in language and motor skills among IPV-exposed children whose parents have psychological distress (Gilbert, Bauer, Carroll, & Downs, 2013).

Furthermore, ongoing internalizing and externalizing behaviors associated with their children's IPV exposure were reported among seven out of the nine participants (78%) despite their separation from the perpetrator. Such acts included anger, regression, being bullied, bullying, and aggression. For example, 003 stated "My son was regressing and cursing. He would punch things and hurt himself. All of this happened when we were in the shelter." Participant 008 stated,

> He still has problems peeing and defecating on himself which started a long time ago because he's scared. He's been bullied in school. You can't raise your voice or look at him because he starts crying. My son also has problems with getting aggressive in school and walks out of the classroom when he gets frustrated or angry. My daughter is very verbal and can be aggressive to students and teachers in school.

Only one of the participants discussed that all of her children except for her five year-old had abusive towards her. When asked about her 11 year-old she noted that "My daughter has meltdowns sometimes and she takes things out on me. All of my kids starting with my oldest daughter to my 11 year-old have been verbally abusive towards me."

Theme 29: Many of the children showed caring towards their mother's post IPV incidents.

When discussing the child's reactions to the IPV incidents data emerged that reflected the internal asset of child caring behaviors. Additionally, four of the parents discussed how their children would try to console and reassure them post-IPV incidents. Participant 002 stated, "My kids would call him a monster and they would try to hug me and reassure me afterwards." Participant 009 verbalized, "She would check on me and ask if I was okay. She and her brother would come in and try to hug me but he wouldn't allow them." Participant 001 stated,

> There were a lot of times when we were in the bedroom and the kids would try knocking on the door calling me. I would tell them, that I was okay and that we were just talking and they would ask why we were so loud. I was so tired of lying to my kids.

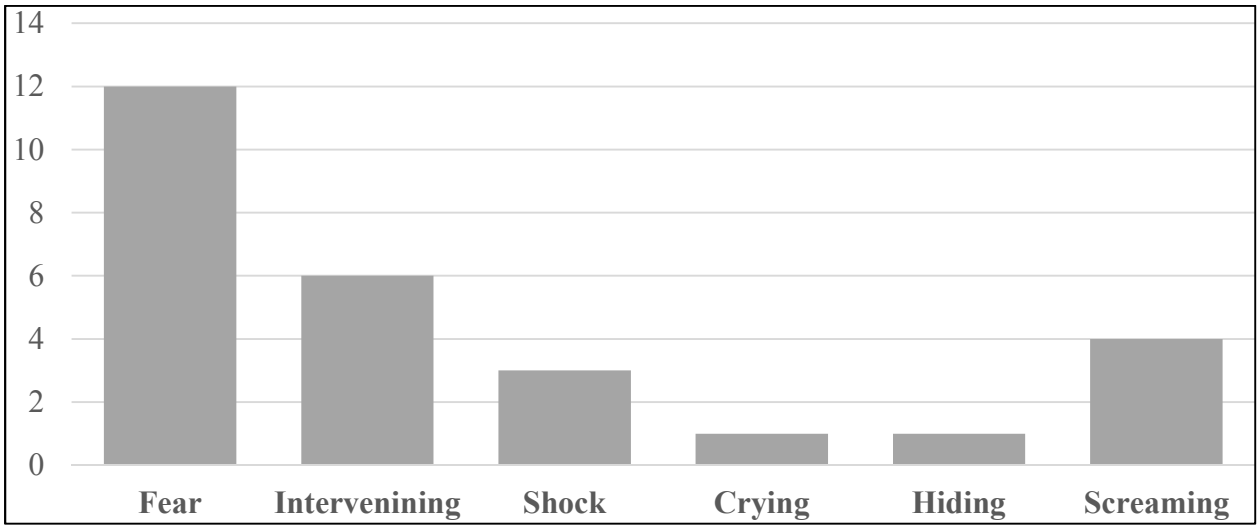

Figure 2. Child reactions during IPV incidents

Theme 30: Some of the children had continued instability postseparation.

Data for theme 30 was coded and categorized based on child responses and setbacks which reflected continued instability. Five (56%) of the participants reported continued instability in their lives that affected their children. For two of them, the instability related to their children being in foster care and for three of them, the instability related to fear of retaliation and the challenges with finding suitable housing in another location. Participant 009 stated that when her kids were placed in foster care:

> The foster parent was basically emotionally and mentally harming my kids. The kids complained that she would threaten them, keep them outside late at night, locked up in the room on weekends, and would leave them alone with another foster child in the home. I had to call an emergency meeting because they stunk, didn't brush their teeth, slept in their clothes, and were only allowed to bath once a week.

Participant 005 stated,

> My son was hospitalized this week because of his behaviors, he has anger issues. They're trying to help him by changing his ADHD and PTSD medicines and monitor his behavior. He is staying with my cousin, his 6-year old brother and two-year old sister and he gets tantrums and starts crying, yelling and screaming for long periods of time.

Participant 001 stated that "right now the 11-year-old knows that daddy is trying to find us… I've been trying to get help to move from where I'm at but housing has denied me everywhere everybody is denying me."

Theme 31: Improvement in academic performance were evident among the IPV-exposed children.

Theme 31 data was derived from feedback obtained from the mothers related to their child's academic performance. Additionally, school performance was examined for each child based on the mother's perceptions of their academic performance (Table 3). The participants were asked how their children performed in school and about their average grades. The mother's reported that most of the children attended regular school and less than one-half required special education services. The participants who had children in special education schools ($n = 4$) verbalized that the services were needed because their children had a genetic (22%) or mental health disorder (45%) disorder, and learning disability's (33%). Participant 009 stated, "My 11 year-old also has a learning disability and is in an individual education program but she's getting A's at a third grade reading level and doing good". Participant 003 verbalized "After he went to the special school while we were in the shelter it was so much better for him. He's now being put

from individual to advanced group work which is so exciting." Additionally, in terms of school performance, three of the mother's reported that their children's grades were better, three of them felt that their kid's grades were good, and three stated that their kid's academic performance was excellent. Participant 006 stated:

> Right now, I see that she's much better because she's getting therapy three times a week and all of the help she needs. She's talking, walking and doing well now. At one point they moved her to a regular school and she did very poorly and was getting aggressive and acting out. That one month was a setback and it was very hard.

Participant 002 verbalized, "My daughter gets A's and B's and is an excellent student." Participant 008 noted:

> He's in a special school because he can't remember what is taught and he has ADHD and PTSD. My son also has problems with getting aggressive in school and walks out of the classroom when he gets frustrated or angry. My daughter is very verbal and can be aggressive to students and to teachers in school. I help him but it's hard because my English isn't that great. I encourage him and try to give small rewards when they do the right thing.

Participant 007 stated,

> She does amazing in school. This past Friday they told me she's student of the month and they're going to have a ceremony and give her a pin. She got 110 in vocabulary and is the only one in kindergarten who got student of the month.

Each child's school performance was discussed separately and there were two mothers who had more than one IPV-exposed child aged 6 to 11 years (Table 4).

Table 4

IPV-exposed Children School Performance (N = 12)

	School Performance					
	Special Education			Non-special Education		
	Better	Good	Excellent	Better	Good	Excellent
%	25%	8%	8%	17%	17%	25%
(n)	(3)	(1)	(1)	(2)	(2)	(3)

Theme 32: Post-separation the children were mostly showing signs of coping, an internal asset.

Examining the mother's perceived resources for their IPV-exposed children was an important theme in this study because I used resilience theory as a framework. To assess this theme, I chose to divide it into two areas which included the IPV-exposed child's internal assets and external resources. The first internal asset explored was categorized as coping.

Internal assets. All (*n = 9*) of the participants felt their children were now coping well despite the child IPV exposure and the unstable environments they had experienced. Each of the participants were asked to describe the coping skills of their IPV-exposed child who met the criteria of being aged six to 11 years. Participant 002 stated,

> She's coping great. She's doing well in school, has friends and I let her be a kid.

She's coping great. She's doing well in school, has friends and I let her be a kid.

> She comes to me, or if I notice something is not right I ask her, and we talk about it. I think it's important that she knows I care and support her in everything.

Participant 007 stated,

> My daughter asks me where I'm going and is one of a kind. She wants to be with me, has a good vocabulary and is just a bright girl. She uses certain words for the right reasons. She loves music, singing, dancing and doing karate, so I'm going to look into dance classes for her.

Participant 006 stated, "It's hard to say because of her disability but I think she's doing much better here than when we were in Puerto Rico. She loves it here especially during the winter months when she can play in the snow."

Nonetheless, for some of the children, the participants ($n = 5$) felt that their coping skills were still a work in progress, but they were on the right path to adjusting. Participant 008 stated, "I think they're doing better than before, but they aren't healed." Participant 003 said "My son asks me questions and is progressing but it's a slow process. He no longer hurts himself and is now more stable." Additionally, despite the challenges of having children in the foster care system, Participant 005 stated, "It was hard for them at the beginning, but they adjusted pretty well" and Participant 009 noted,

> I think that the (new) foster parent has really helped them along with the counseling. Now, when my son and 11-year old argue the foster parent tries to calm them down. She encourages them to talk to each other without yelling. She's able to calm them down and stop them from cursing at each other. They also have rules they have to follow, and they know what they can and can't get away with.

It appeared that the mother's viewed coping regarding their child's behaviors by comparing how they were before and after the IPV exposure.

Theme 33: Most of the children depicted actions of being responsible, trusting and hope.

Regarding a child's other internal assets, taking responsibility for their actions, hope and trust were categorized and coded because they are factors that may foster resilience in individuals who have had adverse childhood experiences (Vitto, 2001). Participant 002 discussed that her 10-year-old daughter "Even when she lies, she admits it. She'll lie about little things like a lost earring". Additionally, with regards to hope and trust, participant 009 expressed that "My 11 year-old is always happy to see me and she tells me over and over how much she loves me. They tell me they want me to be safe." Participant 002 stated, "She believes the things I say because when we were at the shelter there were people who had been there a long time and I made things happen quickly for us to get an apartment." Lastly, two of the participants (22%) discussed that their children showed care for others post-separation. Participant 004 stated "They both love me, they adore me, when I get sick they take care of me" and Participant 003 reported,

> So, the kids know when I go to the bathroom mommy needs that time alone. My daughter sits outside and waits for me to see if I'm okay and my daughter talks to me which helps me. My son tells me mommy is acting crazy again, okay go time-out, and I'll see you later. He's more like alright and dismisses it. He goes to play with his toys.

Theme 34: Some of the children had health issues which they were being treated for.

Theme 34 coded categories included the types of health issues and treatments. Regarding the IPV-exposed children's health, six of the mothers reported that their kids had health issues that were treated with either special education services, counseling, medications or a combination of these remedies. Among the mothers who reported that their children had health conditions (Figure 3), 56% attributed their child's health conditions to the IPV exposure. Participant 008 verbalized,

> He's in a special school because he can't remember what is taught and he has ADHD and PTSD. If all of this was happening to him because of a medical condition, he had in the past it would be different, but that's not the case. His medical conditions come directly as a result of the violence. In the past, she (my daughter) had threatened to kill herself. She's not under any treatment, but I think her anger is from holding things in probably from what she's heard from her brother or saw my abusive relationship when she was 7.

Participant 009 stated,

> My daughter had started cutting herself and is on medication for compulsive disorders because of the stress; she hears noises, is depressed, and sees things that are not there. She's been in psychiatric hospitals because she hurts herself by cutting which started when we were with the abuser.

Two mothers discussed that their children had ADHD/PTSD and were under medical supervision. One of the mother's attributed her son's ADHD/ PTSD to the IPV but, there was one discrepant case where the mother perceived her children's

ADHD/PTSD was due to having lived in numerous shelters over a five-year timeframe and foster care. Participant 005 stated,

"I think the PTSD is from them being in and out of the shelters and ACS" which has important implications because there may be other issues that need to be considered.

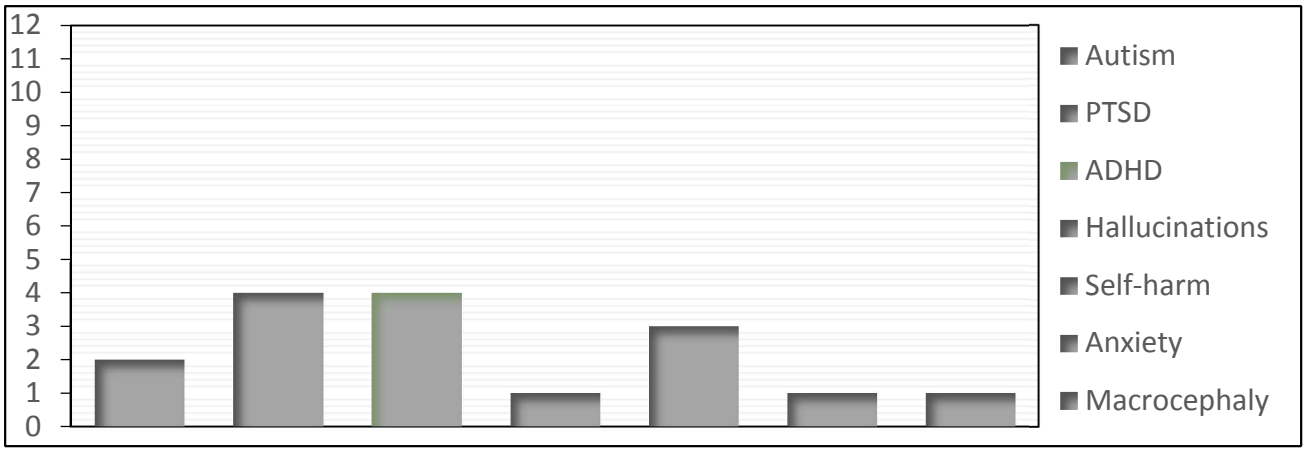

Figure 3. *Reported diagnosed health issues in the IPV exposed children*

Theme 35: At some point, all of the children had a symptom associated with PTSD.

Theme 35 reflected emergent categorized data of children who showed signs of triggers or other reactions. Three of the participants have noted that their children reacted to triggers which may be attributed to PTSD (Levendosky et al., 2013). Participant 003 stated, "Now, when they hear any noise, they get scared and hide." Participant 001 stated,

> It's to the point now that they hear any argument and they start screaming and shaking. We were on a train, and some people started fighting and my 11-year-old he just crouched down and started shaking. I told him that everything was going to be okay and that we were going to get off and he was yelling "get me out, get me out" and I thought oh my gosh. You know, people were looking like I was hurting him because they didn't know what was going on.

Additionally, all of the mothers reported some type of symptom which has been associated with PTSD (APA, 2013; National Institute of Mental Health, n.d.). Participant 003 stated "My daughter and son tend to just stare into space sometimes and they do ask questions." Participant 002 noted, "She would wake up startled or in the night jump up. This was while we were living with her dad and after when we were in the shelter." Participant 007 stated, "She gets nervous and shaky when we bump into him or she hears him speak. It's made me realize that she remembers what's happened in the past. She is afraid of him which gets me angry."

Theme 36: The majority of the children received counseling post-separation and some have continued counseling.

Child external resources were categorized by type of resource which included counseling. In addition to a child's internal assets, multilevel system external resources also play a vital role in resiliency (Gewirtz & Edleson, 2007; Masten, 2001, 2007) primarily because they influence self-esteem, coping skills and mental health (Holt-Lunstad & Uchino, 2015). External resources identified in this study were counseling, friends, school, family members, and the community which included involvement in extracurricular activities. At some point post-separation, 89% of the participant's children had received counseling services, and 58% of the children were still receiving counseling services at the time of the interviews. When I asked the mothers who their child would talk to about the IPV exposure and how they thought it might have helped, 44% (n=4) stated that their child would talk to their therapist and this comprised a sample of 58% of the IPV-exposed children in the study. Participant 003 stated "They would talk to their

therapist. They have been with the same therapist for a while, and they open up with her. After they see the therapist, my son is more at ease and not so hyper." Participant 009 stated,

> They would go to their counselors, and I know they talk about it with them. My daughter used to be really upset with me, and I notice that she's not that way anymore. She's calmer now and loving to me when we see each other on the visits.

Participant 008 stated,

> The kids don't talk to me about their sessions. I do meet with their therapists. My daughter's therapist gets along really well with her, and she knows what's going on. I ask her to advise her and to let me know if there are things I could do better as a parent.

Participant 006 stated "She has never discussed anything about the abuse with anyone because she was so young when it happened. Also, she is mentally challenged because of the macrocephaly." Thus, for the children who remained in counseling, their mother's viewed it as a vital source of support for them.

Theme 37: Several children interacted regularly with friends and school personnel.

Another external resource was categorized for friends and relationships with school personnel. In addition to counseling, another external resource which 78% ($n = 7$) of the participants perceived was supportive to their IPV-exposed children were their friends. Participant 002 stated that her daughter "She has friends and is involved in school. Even when we were moved from one shelter to another, I kept her in the same

school zone so she wouldn't have to start all over." Participant 006 noted that her daughter "She gets along well with others and is very friendly. I have to be careful with her because she makes friends very easily and can get kidnapped." Participant 003 stated,

> He does have friends and likes to be around older kids. I guess there more of a challenge to him, and he loves challenges. He's good with family members, and he wants a brother. When I'm talking with strangers, he asks them a lot of questions and gets protective of me. They're jealous of other kids when they're around me.

In contrast, about her 11-year-old daughter, Participant 009 stated "My daughter doesn't have any friends except for the one girl she likes…She's very quiet." Participant 008 said that her daughter "She has friends, but her friendships don't last long because she doesn't like to be told what to do."

Also, school personnel were also a perceived source of social support for the children among 78% of the participants. Participant 007 stated "She has friends in school and loves her teacher. She's happy and playful around her friends." Participant 001 indicated,

> The principal called me the other day to say he didn't understand what was going on with him. He said he's not the same and I explain what was going on, and he said okay now I understand. He sat with him and said if you need anything I'm here, and they started him in school counseling.

Participant 002 stated,

> My daughter teachers call me and tell me what a pleasure it is to have her in their classroom. If I hear something bad, I'm like what?

Participant 005 stated,

> There have been a couple of schools where the teachers are very nice and supportive of the kids and what they go through. One Christmas, the principal of their school and his wife, took us all out to dinner at IHOP and bought presents for them. This was when the kids were all in the same charter school. I heard that other parents are allowed to go to parent-teacher conferences even when they're in foster care, but the judge had put an order of protection against me, so I had to stay away from my kids. I don't understand because I have never abused my kids. They had food, a roof over their head, not beaten and had clean clothes.

Theme 38: The mother-child relationship was perceived to be robust.

The mother-child relationship was coded and categorized, as another external resource, but the codes included relationship, activities and perceived bond. In addition to counseling, friends, and school, relationships with family members including the mother, were also external resources identified by the participants in this study. All of the participants reported that they had a supportive bond with their IPV-exposed children aged 6 to 11 years. When asked who their child would talk to about the incidents 56% of the mothers perceived that the child would speak to them. Participant 003 stated "My kids are everything to me. I try to talk to them and encourage them, to be honest with their therapist and me." Participant 001 stated,

> He usually comes to me. I've never had a problem with my kids telling me stuff like they come to me they know that the only protection they have is me. They don't look for anybody. I've always been open to them and tell them if you have a problem come to me. Don't keep it to yourself. Always talk because if you talk, you'll get somewhere. If you keep it inside, it's just going to hurt you, and I've learned that here because I always kept everything inside. I feel that it helps them talk about it with me because I explain why we can't go back.

Participant 004 stated,

> We have that open relationship. I always tell me that I will be their friend, mother, anything they want me to be. But, I don't want you going out there and divulge our business out there because nobody needs to know our business, personal business.

Also, when asked about the relationship they had with their children, all of the participants perceived that their relationship and interactions with their kids were positive. Participant 007 said,

> She asks me things, and I try to break it down to her level so she can understand that yelling or hitting someone is not good. I'm her mother, big sister, best friend, cousin, just a little bit of everything. We play together and have mother-daughter days.

Participant 002 stated,

> She's crazy about me, and I always wanted to have that because I never had that with my mom. I make sure I tell them and that they feel loved. I didn't have that,

> so I try to be her mother, friend and show them all the love I can give. Despite everything we have gone through, we have always had an excellent relationship. She and her brother were always my top priority. One time we spoke about some things about her father because I noticed she was very upset and I had to hug her and we cried together.

Participant 009, who had discussed that her daughter who's now in foster care, was verbally abusive towards her when she was in the relationship with the perpetrator, said:

> My 11 year-old is always happy to see me, and she tells me over and over how much she loves me. My daughter used to be really upset with me, and I notice that she's not that way anymore. She's calmer now and loving to me when we see each other on the visits.

Two of the participants described a positive relationship with their children but also verbalized some challenges. Participant 006, whose daughter has macrocephaly, stated:

> We get along but, like I said, she's a handful. I feel that our relationship has its ups and downs, but I think that has to do with her way of being. Sometimes she doesn't listen and can be disrespectful. She has a strong personality and wants to do whatever she feels like doing. I've taken her to therapy and have been advised to give her time out if she's not following directions.

Participant 005, who had five children between the ages of two to 13, stated,

> It's good. We have our days too. What I did was, for the summer, I sent the three oldest ones (aged 13, 9 & 8) to sleep away camp for two weeks so that I could get

> a little break. So I put them there, and they liked it. I was worried that they missed me, but they didn't miss me.
>
> The mother's also discussed how they encourage and help their kids with school work.

Participant 004 stated,

> When it comes to my children's education I don't play around. Why because if I gave my freedom to raise them then why should I let them or anyone ruin their life. I gave them the example by going to school and having a career.

Participant 001 stated "He's focusing in school and I make them read for at least an hour and do their homework. They're like "mommy you're strict" but I tell them that I want them to do well in school." Participant 008 verbalized "I help him but it's hard because my English isn't that great. I encourage him and try to give small rewards when they do the right thing."

Theme 39: Many of the children had close relationships with siblings, family figures and other family members.

Another external resource was categorized for relationships with siblings, family figures and other family members. Except for one of the participants, 8 of the IPV-exposed children had siblings and 88% ($n = 7$) either lived with their siblings or had regular contact with them. Participant 003 noted,

> As sibling's they get along really well. My son is very patient with his sister. He tells her that boys don't hit girls and that he's not like her father. I talked to him about baby jail and explained that dad went to jail for hitting.

Participant 009 stated that her 11-year-old daughter "She knows her rights and defends her siblings." Participant 001 stated that her 11-year-old son,

> He's the "big brother" to the 13 year-old and face times with his older brother every day. He was always with his older brother so being away from him has been hard because they were always together. He protects his little brother.

Participant 004 stated,

> As brother and sister, they have a love-hate relationship cause that's how siblings are. When they're next to each other, they pick on each other, antagonize each other. But, if one doesn't come home on time from school they worry about it and will knock on my door to remind me that one hasn't come from school. They tattle one on the other (laughs). It's like I tell them that you guys need to get along with each other because the day that I'm not here, you only have each other.

Two of the participants whose children had siblings noted that their children had minimal relationships or no contact with some of them. Participant 002 stated,

> My daughter doesn't have a relationship with her older siblings. My older daughter is like my mother, and I'm convinced that my mother has put things in their head. I feel like they resent my 10-year-old and her brother.

Family members or family figures were other sources of external resources for the children identified by 56% (n=5) of the participants. Participant 003 stated, "They love my mother and the rest of my family." Participant 007, whose daughter is an only child, said that in addition to their relationship,

> She's also very close to my mother, and they have an amazing relationship. I was allowing my daughter time with his mother, and she would let him see her even though she wasn't supposed to. So, now I don't let her visit her grandmother or anyone in his family. I think that's not a good environment for my daughter because he's abusive towards his mother, his mother's boyfriends, and the girlfriend that he has now.

Participant 006, whose daughter doesn't have contact with her sibling's in Puerto Rico, stated,

> My child is close to my niece who stays with me on and off. She doesn't know her father, but she thinks my boyfriend is her daddy even though she calls him by his name. He has a strict character, and she respects him.

Theme 40: Most of the children confided in their siblings about the IPV.

Theme 40 reflected the types of relationships that the IPV-exposed children had with their siblings and whether they confided in them about the IPV. In this study, 43% of the participants who had children with sibling relationships discussed that their kids talked to each other about the IPV. Participant 008 noted that "My daughter was a newborn when I was with her father in Puerto Rico. However, she was born with anxiety. I believe she's spoken with her brother and he has told her things that happened with their father." Participant 004 discussed that when the IPV was occurring "Well my son, my grandson, being that he was deaf and he doesn't realize only when my daughter would tap him to tell him what's going on." In contrast, Participant 001 stated,

> They don't talk about their experiences with what has happened because I'm always there and I always tell my mom to make sure that my oldest son (15 year-old) doesn't talk to them about it or mention his dad. My thirteen-year-old always asks (about his dad) a million questions, but his (older) brother tells him he doesn't know anything or his number. The little one (11 year-old) knows how to keep it to himself because he knows it affects his brother badly. At the time, I didn't want to say anything because I didn't want them thinking that I did something to provoke him because that's what everybody thinks.

Theme 41: Some of the children were involved in extracurricular activities.

Theme 41 was coded and categorized as an external resource in terms of community support in extracurricular activities. Additionally, the community and involvement in extracurricular activities are system-related resources that can aid in the resiliency of children who have had adverse experiences (Aymer, 2008; Hardaway, McLoyd, & Wood, 2012; Tiet, Huizinga, & Byrnes, 2010). When the participants were asked about extracurricular activities in the community, 3 of the participants had involved their children in extracurricular activities post-separation. Participant 008 stated,

> A friend of mine paid for him to join the boy scouts and he loves it. I go to church with my husband and kids. They really enjoy singing and getting involved in church activities. I'm not a fanatic about the church, but I find that it reinforces communication with others, respect, their faith in God and it's educational. One needs to have faith, and I feel this has helped my kids. My son preaches, sings and has learned to explain himself which has been a good diversion for him. Everyone

> loves him, and they try to involve him in activities. She's (9-year-old daughter) involved in church activities, but not as much as my son and I enrolled her in girl scouts.

Participant 002 stated,

> She's the captain of her cheerleading team, the school treasurer and she likes to get involved in everything and excel in everything she does. She used to be in tennis which was an escape to the abuse when we were living in the house. She qualified for a program where she goes to a college during the summer for a few weeks and lives in the dorms. She stays there like a grown adult who's going to college. She really likes that, and it's better than her being here during the summer.

Theme 42: Most of the perpetrators were the biological fathers of the IPV-exposed children.

Theme 42 coded and categorized data emerged from the mothers reports of the perpetrators as fathers to the IPV-exposed children. There are no universally identified characteristics or traits for men who are perpetrators of domestic violence (Mederos, n.d.). All of the participants verbalized that the perpetrators had been males and 78% (*n* = *7*) noted that they were the biological fathers of their IPV-exposed children. Participant 002 verbalized "He's the father to the two younger kids and we were together off and on for 13 years." Participant 003 noted "Then, I got pregnant and my boyfriend said that he had me since I was going to have his baby."

Theme 43: Most of the perpetrators tried to control the children.

Coded and categorized data for theme 43 included behaviors exhibited by the perpetrators towards the IPV-exposed children. According to 8 of the mothers, the perpetrators had demonstrated impatience, threatening, controlling, verbally, or physically abusive behaviors towards their children at some point in the relationship. When asked if their ex-partners tried to control her children, Participant 001 noted that her 11-year-old son witnessed his father hitting his older brother, she stated:

> They would get involved by trying to hit their dad, throw stuff at him, and yell at him to "leave my mommy alone, mommy didn't do nothing. One of those times was when my oldest son got hit with the bat because he physically pushed him. They would try to hit him and protect me but he would always yell at them and hit them and they would stand in the corner and cry.

Participant 007 described an incident which occurred when she was with her daughter. She noted:

> He cursed at her and was walking towards her that I had to put her behind me and I had to get in front of her and I told him I just wish you would. I don't know if he was trying to scare her because he does that. He likes to put fear in people and I could tell she got nervous because he had that real aggressive voice.

Participant 009 verbalized, "Yes, there were times when he tried to control my kids too. They weren't allowed to show me any affection or go outside. He would tell my 11-year-old to just go to sleep." In addition, one of the mother's discussed how the perpetrator attempted to bribe her daughter post IPV incidents. Participant 004 said that her ex-

partner “He would always try to bribe my daughter, buy her things that’s how he would have her on his side.”

Theme 44: Alcohol and illegal drug use by the perpetrator played a role in IPV for most of the mothers.

Theme 44 was coded and categorized for involvement of perpetrator substance abuse (legal and illegal) and how it influenced their behaviors. The mothers discussed that the perpetrators use of alcohol and illegal drug played a role in IPV incidents and influenced the perpetrator's aggressive behaviors. All of the participants explained that their ex-partners drank alcohol and 78% (*n = 7*) of them noted that their ex-partners had also abused illegal drugs when they were in the relationship. Participant 003 stated “In Florida, he started doing drugs and blaming me for everything he was doing. That’s when the physical abuse started.” Participant 001 said, “He didn’t care if he didn’t have his alcohol or drugs he would go ballistic.” Participant 008 said, “When he drank alcohol he would get even more abusive and accuse me of things I didn’t do.”

Despite the IPV and the perpetrator’s substance abuse, 56% of the participants had discussed that their family members had been sources of support for themselves and their children when they were in the relationship with the batterer. Participant 001 stated, “When we were home they had good grades because they were busy and stable even with the abuse I suffered with their dad. They had my mom and their cousins so they would go there every day.” Participant 005 stated “I’m close to some of my siblings. I see my younger sister every day. My kids all had relationships with their cousins and I show them pictures even though they don’t see them.” Participant 003 stated “I have always

remained close to my family." In addition, Participant 002 stated, "Afterwards (IPV incidents), I left with my daughter and I went to my brother's house to give him a break mostly because of my daughter."

Theme 45: Most of the children don't have contact with the perpetrator.

Theme 45 data was coded and categorized regarding the child's contact and feelings towards the perpetrator. Most of the mother's (*n = 6*) noted that their children didn't have any contact with the perpetrator regardless of whether he was their biological father or not. Five of the mothers felt that their kids harbored negative feelings towards the perpetrator. Participant 001 said "My 11-year-old hates his father he says he doesn't want to look at him or see him. He wants nothing to do with that man." Participant 008 verbalized that her 10-year-old son:

> He says that what his father did to me is unforgiveable and I explain that he needs to understand that he's not like him and never will be. They have no contact with their biological father. Right now I'm going to court to fight for full custody of them because I left Puerto Rico.

In one case, the parental rights of the perpetrator had been terminated through the court system by the mother, but the daughter didn't understand the situation even though she had, up until recently, been exposed to the ex-perpetrators aggressive behaviors. Participant 007 stated,

> I got a five-year order of protection and was lucky that I got a judge who understood me and took his parental rights away. My daughter wants to have a father figure, and I'm still trying to figure that out.

Theme 46: A few children had or wanted to have contact with the perpetrator.

Theme 46 data also emerged from the child's contact and feelings towards the perpetrator. Nonetheless, despite their children's IPV exposure, 4 of the mother's described that their children wanted to or had some contact with the perpetrator. Participant 007 stated "I'm the one who gets emotional about things, especially during special occasions. She'll ask about her dad attending events and it makes me cry." Participant 004 stated "Sometimes my daughter will mention him and it's hard for her. She would talk about him like her dad, and she would introduce him as her stepdad."

Theme 47: The majority of the perpetrators didn't have visitation or pay child support.

Coded and categorized data for theme 47 related to the perpetrators visitation and financial support of the children. Most of the perpetrators, who were the biological fathers of the children didn't have visitation or pay child support. Thus, among the nine participants, only one of them received child support for her two children from their biological fathers, and two of them had a parenting relationship which allowed for child visitation. When asked about child support Participant 003 stated,

> Yes, they both do. He didn't want to pay child support and didn't show up to court the first time but he was obligated to pay it by the court. My daughter's father he takes both of them, and I do involve him in the kid's events like birthday parties. We had a birthday party last week for my daughter, and I let him come. I had family there and knew nothing would happen, so I felt okay. He got mad at me though because I wasn't making friends with the girls that came with his guy

> friends. He still tries to control me when he speaks to my daughter and son or attends school events.

Participant 005 verbalized:

> I feel like the system is backwards because they want to help you after the kids are taken from you. They are quick to allow their father visitation even though he's been in and out of jail but they want me to do services and drug testing which isn't fair to me.

Participant 007 verbalized,

> I'm here struggling to raise my daughter by myself and he looked like a million bucks all Gucci out. He was wearing $700.00 jeans and $1,000.00 sneakers on his feet and he doesn't even try to help out with his daughter. If he doesn't give it to me directly, he can help by giving it to his mother for my child.

Also, one of the participants allowed the ex-partner to speak with the children telephonically, but he didn't pay child support nor does he have visitation rights.

Participant 002 stated,

> He tried to take me to court for visitation and custody which was another form of trying to abuse and control me. Eventually, he dropped the charges because he saw I wasn't budging. I will never respect that man. He'll call my daughter from time to time on the cell phone, but it's just to say hello. He doesn't provide any support for the kids and never asks if they need anything.

Participant 007 who legally removed the perpetrators rights to visitation, stated,

> I heard he's taking parenting classes, but there are other things he needs to do before he has contact with his daughter. He's completed 30 days of parenting classes. I also requested domestic violence, anger management, and a drug program before he's allowed to spend time with his daughter even if its supervised visits at first.

In sum, the characteristics of the perpetrators that resonated most during the interviews included controlling behaviors towards the children, legal and illegal substance abuse, and tactics to try to lure the kids. Three participants allow their children to have contact with their fathers, and only one participant would consider allowing supervised contact if her daughter's father completes the court mandated programs.

Theme 48: The mothers were empowered to help others by sharing some of their insights.

The 48th theme emerged from data categorized from the second interviews and was derived from the participants who shared some of their insights regarding IPV. I found that the participants were empowered to share what they had learned from talking to other participants and having been in the system with the intention of helping others better understand. Participant 002 stated,

> I notice that a lot of women get into abusive relationships because they value more what someone else thinks about them. It's like they need that reassurance from another person. After talking to some of the women, I notice that we have a lot of things in common like having been abused at an early age or seeing that in our own parents. I know for me, I felt like I needed to be reassured and told that I

> was a good person. I needed to be reassured that I was a good person. When you rely on that and show someone else, it becomes a power trip for them. They don't see you as their equal, and it comes down to having a real low self-esteem. Even if you think he's lying to you, you just want to hear it, and that's crazy. I'm glad that changed for me because with my kid's father, that's what I needed the most. I needed him to tell me good things. I waited for those times but wasted a lot of time. People want to be told so much good things, and I think it stems from what you went through when you were younger. I didn't get it from my mother, so I needed someone to tell me that.

Participant 007 stated,

> All it takes is one thing to happen, and it affects your life forever especially if you don't get out on time. If he wouldn't have had went away, I'm sure I would still be in the same situation because I wouldn't know how to leave. Many people don't know when to leave, and sometimes it's too late especially when there aren't any kids. When kids are involved, it should wake you up and if it doesn't then you're so deep into it that you're not putting your child first. I think having kids are a savior, so you're saving your life and the life of your child.

Participant 009 stated,

> I want to know when I'm going to be normal? I just want things to be back to normal with me and my kids. I heard that after 18 months, my kids could be adopted if they're still in the system. That scares me because I won't give them up

> forever. I just want them back. I don't understand why it's so hard for victims and why we don't get the help we need when we need to get our kids back.

Theme 49: Some of the mothers want transparency with IPV screening procedures.

Data for theme 49 emerged when the participants discussed their experiences with IPV screenings and was categorized as recommendations for IPV screenings which they felt would enhance disclosure. Additionally, with regards to IPV screenings, Participant 001 stated "I want to be screened without being judged" and Participant 009 reported,

> I think if they screen you, they should explain that your kids won't be taken away and that they can protect you. Usually, you're scared to talk because you're afraid because of threats from the abuser or having your kids taken away.

Participant 002 stated"

> A lot of things happen that don't get spoken about like you confide and then your kids are being taken away and that makes it tricky too. I think people probably want to speak about some things but they don't want to feel like they're getting in trouble for it, for being honest and open and getting ready to move forward from an unhealthy relationship.

Theme 50: Most of the mothers provided feedback on resources that are lacking for themselves and their children.

For the last theme, the data was coded and categorized into resources which included housing, mentoring programs, skills training, job placement, anger-management evaluations for children, experienced empathetic case workers, bilingual staff, and mother-child activities. Regarding resources, at the second interview, all of the women (*n*

= *8*) had requests to make based on what they've experienced for themselves and/or their children. Participant 007 stated,

> There should be like a sister-mother type thing that allows the woman to build a relationship where she could eventually speak up. It was hard for me to open up and I don't trust a lot of people, so they need to have a person who checks up on you, can visit you, have play dates with the kids, and I think she'll definitely open up.

This was very similar to suggestions made by Participant 003 who stated "We need more mommy and children activities and events. Children need to forget, and women want to feel safe and be happy. It will help them move forward. More playdates among the women to support each other." Participant 008 also stated,

> It gets me frustrated that there isn't a place where women who have been victims of domestic violence can go and get engaged in workshops or other group activities. I would like for there to be a place where people could go and reflect or just have fun. The kids should also be engaged in activities because they're victims too. Places where victims and their children can go and be normal.

Additional resources requested included skills training and job placement, more bilingual services, empathetic case workers who have survived IPV experiences themselves, and as stated by Participant 009,

> The kids need to be fully evaluated, and they should also go to anger management. These things should be done automatically without a parent having to ask. I mean, if I see it, they must too. I also think we need more housing

opportunities. We need safe housing for our families and not to be put on waiting lists. People just need to do their job and care.

Discrepant Cases

Cross-case, if-then tests and repeated analysis were performed for all cases to capture any discrepancies. One discrepant case was further analyzed and disclosed (Miles et al., 2014; Patton, 2015). In this case, Participant 005 stated, "I think the PTSD is from them being in and out of the shelters and ACS." I included the case discrepancy in the Chapter 5 interpretation section as evidence of other factors that may have some impact on the issue.

Summary

The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of Puerto Rican mothers who were victims of intimate partner violence and their perceptions of how their IPV-exposed children aged 6 to 11 were impacted. The recruited population of mothers or legal guardians for the study included nine low-income participants who lived in the Bronx borough of New York City. The individuals who participated in this study provided consent, in Spanish or English, and extensive details regarding the phenomena of their lived experiences with IPV and how they perceived that IPV exposure might have impacted their children aged 6 to 11 years.

The semi-structured initial and follow up interviews provided opportunities to capture relevant statements regarding their lived experiences with the phenomena. I outlined the sampling and recruitment procedures, the research questions, data collection

and data analysis procedures, measures taken to ensure trustworthiness, themes, and narrative descriptions to support the themes. The feedback obtained from the participants are their personal statements of their lived experiences with IPV and their perceptions of how IPV exposure may have impacted their children aged 6 to 11 years. Additionally, I integrated one discrepant case into the results.

The procedures utilized for data analysis began with data collection and reflexivity. Additionally, data analysis integrated extensive and repetitive reviews of the interviews and they were transcribed verbatim, audited and edited for grammar as well as stumbles. NVivo 11 Plus was used for journaling, to import the edited interview transcripts after member checking was completed, to develop questions for the second interviews, to add observation memos, to code the interviews, and to develop the 50 detailed themes.

The 50 themes produced illustrated the phenomena of the lived experiences of Puerto Rican mothers who were victims of IPV and their perceptions of how their IPV-exposed children aged 6 to 11 may have been impacted. The qualitative research questions were open-ended, broad, non-directional and consistent with phenomenology (Creswell, 2013, Miles et al., 2014). The first research question of the lived experiences of Puerto Rican mothers who are victims of IPV resulted in 25 emergent themes. Twenty-five themes also emerged from the second research questions which related to the Puerto Rican mother's perceptions of how IPV exposure may have impacted their children aged 6 to 11 years. The relationship of the responses throughout Chapter 4 coincided with the data and were demonstrative of the participant's narrative statements. In this study, the

Puerto Rican mothers who participated distinctly expressed the essence of their lived experiences of having been a victim of IPV and their perceptions of how IPV exposure may have impacted their children aged six to 11 years.

In Chapter 5, I will provide an interpretation of the findings as compared with the peer-reviewed literature from Chapter 2 and the theoretical framework of resilience, discuss the study's limitations, make recommendations for further research, and examine the implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of mothers who were victims of intimate partner violence and their perceptions of how exposure to intimate partner violence may have influenced their IPV-exposed children aged 6 to 11 years. I sought to explore the *what*, and *how* of the participant's lived experiences by collecting and analyzing one-on-one interview, observational, and reflective data.

I conducted this study because the literature on child exposure to IPV among Puerto Rican children is limited (Mogro-Wilson et al., 2013) and a cultural mindset is essential to working with individuals, families, and communities to eliminate gender discrimination, stereotypes and child exposure to IPV (Nahavandi, 2012). Also, I conducted this study because there was a need to explore how the unique subcultural values and beliefs of the Hispanic subgroup of Puerto Rican's may impact resiliency. Thus, examining resiliency from a cultural perspective was viewed as vital to informing effective culturally tailored programs which were based on the expectations of the subgroup. The alignment of education and intervention programs with the subgroup's values and beliefs could aid in addressing the unique cultural conflicts, barriers and challenges they may encounter (Amanor-Boadu et al., 2012; Aymer, 2008; Fine et al., 2006; Milan & Wortel, 2015). Also, the findings from this study can support families and children exposed to IPV in developing resiliency over time (Masten, 2007, 2014).

The key findings from this study were that the Puerto Rican mothers who participated endured an array of IPV (verbal, emotional, physical, economic, and sexual abuse, as well as coercive tactics) which escalated over time despite some of their efforts to resist it. All of them stayed in the relationship because they wanted to keep the family unit together. From a cultural perspective, they talked about the importance of family, unity, and communication even though 67% of them had experienced trauma during their childhood and 56% had limited or no contact with their families post-separation. Nonetheless, at some point, each of the women realized that their expectations for a life without IPV were unrealistic and they separated from their ex-partners primarily by going into hiding. All of them discussed that they separated because they either feared for their lives and because of the effects it was having on their children. In sum, the IPV affected their family relationships, employment, health, and their children in many ways.

When they separated from their partners, most of them found themselves isolated and living in domestic violence or family shelters which were not conducive to rearing their children. They struggled to learn how to navigate the domestic violence and legal system to seek help for themselves and their IPV-exposed children but most encountered barriers along the way. Involvement with ACS, lack of support from shelter caseworkers, housing limitations, and the legal system presented as obstacles for most of the women.

As for the children, many of them were exposed to IPV in utero and were direct witnesses to the IPV. Verbal and physical abuse were most commonly witnessed by the IPV-exposed children. Postseparation the mothers sought counseling for the majority of the children and themselves. Fear, anger, internalizing, and externalizing behaviors were

described as reactions they had noticed in their children. However, all of the participants felt that post-separation the children's behaviors were stabilizing and that they were showing signs of coping which was an internal asset. The mother-child relationship was perceived to be robust, and several of the children had siblings, friends and other family members which they interacted with on a regular basis.

Except for two of the women, the rest of them verbalized that their relationships were not initially abusive. Nonetheless, as their relationships progressed, eight of the nine women discussed how it escalated. Based on the findings, alcohol, illegal drugs or both played a role in IPV for the ex-partners of 89% of the participants. Despite the escalating abuse for all but one of the woman, 85% of the remaining eight women discussed that they had returned to their perpetrators at some point after having separated. A total of three children, from two of the participants, have some contact with the ex partners postseparation but only one mother described having a co-parenting relationship. Six of the seven remaining mother's kids have no contact with the perpetrator, and one participant would consider supervised visits under certain conditions.

Four of the participants who attended the second interview felt empowered to discuss insights they had learned about having been involved in IPV relationships. All of the participants who attended the second interview (89%) also discussed IPV screenings. One (12.5%) stated she had never been screened, three (37.5%) said they had been screened by physician's and were honest, and the shelter screened two (25%) but only two (25%) discussed that they were screened but were not honest due to fear. Additionally, all of the women who attended the second interview discussed some

resources they felt were lacking but would help women with IPV experiences and IPV-exposed children. Needed resources included skills training programs and job placement, more support and empathy from domestic violence shelters, ACS and the legal system, better housing opportunities, increased access to information, anger management evaluations and services for IPV-exposed children, mentoring programs, and non-IPV related activities and programs for moms and their IPV-exposed children.

Interpretation of the Findings

Ten themes emerged when I analyzed the study findings. The following section will address the themes in response to the two research questions in comparison to what has been found in the peer-reviewed literature described in Chapter 2. Research Question 1: What are the lived experiences of Puerto Rican mothers who are victims of IPV?

Theme 1: Most of the mothers endured an array of IPV which escalated over time.

The first theme identified related to the types, initiation, and duration of IPV experiences of the participants. The Puerto Rican mother's provided vivid descriptions of the IPV inflicted on them by their ex-partners which included stalking, verbal, physical, sexual, and economic abuse as well as coercive tactics. Thus, the types of IPV were consistent with the definitions of IPV in the literature (Black et al., 2011; Breiding et al., 2015; WHO, 2002). One new finding was that the duration of the IPV (M = 6.4, SD = 4.81) was about five years less than the 11-year average reported in the literature (Triantafyllou, Wang, & North, 2016) which may have implications for screenings, early interventions and referrals. The majority of the mothers had cohabitating relationships with their ex partners and a mean of 3.4 children, aged 6 to 11 years, living in the home

which is higher than the average estimate of two children (McDonald et al., 2006). Except for one participant, the majority of them reported accounts of escalating abuse over time which has been associated with increased risks of child lifetime rates of IPV exposure (Hamby et al., 2011). Individual risk factors associated with IPV by the CDC (2016) which were relevant to the participant's included low educational attainment, unemployment, having young children, and having a low income (see table 1).

Theme 2: Many mothers attempted to avoid escalation of IPV incidents.

In the second theme, several of the participants discussed that they would make excuses for the perpetrators behaviors, fight back, or would withhold intimate relations. The literature reflects that battered women may try to deescalate abusive incidents which occur infront of their children (Louis & Johnson, 2017).Additionally, as depicted in the cycle of abuse, all of the participants described how they had on and off relationships with their ex-partners who would eventually return to the same behaviors. Many of the participants expressed that their ex-partners would abuse them for no reason. Thus, as noted in the literature, the lack of adherence to the honor traditions by the participants may have also been influenced by the IPV not having been perceived as being honor related (Dietrich & Schuett, 2013). Also, the actions taken by the participants could be attributed to the self-sacrificing and endurance of suffering associated with marianismo among mothers (Fine et al., 2006; Mogro-Wilson, 2013). Thus, as noted by Samsel (2013), in some cases, the victims of IPV try to avoid escalation by covering up, resisting, submitting, or returning to the perpetrator. Additionally, the literature reflects that Puerto Rican mother's also feel a

duty to resist when the IPV is occurring in the presence of their children because of their values of dignity and respect (Fine et al., 2006).

Theme 3: Most of the women verbalized that their relationships were not initially abusive.

In this study, the majority of the women discussed that their relationships were not abusive initially but some of the participants discussed that they had experienced controlling behaviors during courtship. The findings that the perpetrators were not considered to be abusive early in the relationship are consistent with the literature on the honeymoon phase of the cycle of violence where couples are getting acquainted with each other (Walker, 1979; WHO, 2014).

Theme 4: Most of the mothers noted that fear, emotional and physical disabilities influenced employment.

At the time of the interviews, none of the participants were employed, and five of them reported that their employment capabilities were affected by the IPV. All of the participants relied on various federal, state and grant funded programs to support themselves and their children. In 2012, the maximum TANF allowance for one parent with two kids living in New York was $770.00 monthly which was comparable to a 50% poverty-level income (Falk, 2014). TANF benefits combined with $339.00 of SNAP benefits, totaled $1,109.00 per month and was equivalent to 70% of the Federal Poverty Level (Falk, 2014). The reasons they described for not being employed included the perpetrators controlling behaviors in the workplace, physical ailments, having been embarrassed, and lack of support for childrearing. Workplace harassment, loss of work

days due to mental and physical ailments affect productivity and have been attributed to employment instability as a result of IPV (Crowne et al., 2011; Logan, Shannon, Cole, & Swanberg, 2007). Thus, the findings in this study were consistent with the literature on employment stability among battered women.

Theme 5: Most of the mothers had encounters with ACS.

Most of the participants had ACS experiences with their IPV-exposed children and the findings were consistent with other studies which reveal an up to a 60% rate of child abuse, neglect or maltreatment in households with IPV-exposed children (Goddard & Bedi, 2010; Hartley, 2004). In New York State the issue of children who witness domestic violence in their homes including the circumstances that constitute witnessing isn't addressed in the New York State Child Protective Services Act of 1973 (MCKinney, 1976). ACS is responsible for providing preventive and foster care services to at-risk families by partnering with external nonprofit organizations to enhance stabilization (City of New York, 2016). A total of five participants discussed some involvement with ACS. Three of the ACS cases were related to IPV issues and were reported by police officers. In the remaining two cases, the children were removed from the home for unjustified allegations of child abuse and neglect per the participants. However, in one discrepant case the mother reported that she and her children had been receiving protective services from ACS for the last 11 years since she was aged 18 years. The findings of mandatory reporting, ACS investigations of child IPV-exposure cases due to the high co-occurrence rates of child abuse and neglect with IPV, and the concept of mother-blaming are

controversial topics which have been well documented in the literature (Alaggia et al., 2015; Groves et al., 2004; Hartley, 2004).

Theme 6: Most of the mother's had to choose whether to disclose IPV and feared losing their children.

During the second interview the participants (*n = 8*) discussed how IPV screening procedures influenced their IPV experiences. Four of the mothers reported having been screened for IPV by a physician, two had never been screened and two recalled being screened by domestic violence organizations. Women who were screened by domestic violence organizations reported being honest whereas the women who were screened by their physicians were either coerced or not entirely honest about the IPV. One mother verbalized she received a referral for counseling from her doctor but no referrals were provided for her IPV-exposed children. The other mother stated that she was coerced into being honest by the police who threatened to call ACS. The findings of low compliance rates by healthcare professionals for IPV screenings despite the USPSTF (2013) recommendations (Alaggia et al., 2015; Sprague et al., 2012; Taft et al., 2013) and the fear of admitting to IPV victimization by Puerto Rican and Latina women are well documented in the literature (Ahrens et al., 2010; Dietrich & Schuett, 2013; Mogro-Wilson, 2013).

Theme 7: Once separated, most found themselves isolated and living in shelters which were not conducive to rearing their children.

All of the mothers, with the exception of one discrepant case where the mother and her children reported living in and out of shelters for about five years, had lived in

shelters for a timeframe of three months to two years postseparation. The majority of the mother's reported that they were moved frequently from one shelter to another, in different boroughs, which disrupted most of the children's schooling. They also reported that the shelters were unsafe, overcrowded and infested with insects and rodents. Thus, another new finding related to all of the mother's experiences with living in shelters post-separation and this is a relevant finding because unstable housing may impact the resiliency of children and the issue has implications for future research (National Scientific Council on the Developing Child, 2009). Unstable housing may cause toxic stress that can negatively impact child development, learning as well as their mental and physical health (National Scientific Council on the Developing Child, 2009). The complaints voiced by the study participants were consistent with the findings from a New York City report which audited the Department of Homeless Services who is responsible for overseeing 155 shelters that provide services to almost 13,000 and about 24,000 children (Stringer, 2015). In New York State, there are minimum requirements for family, domestic violence, and homeless shelters to attain certification from the New York State Office of Temporary and Disability Assistance (n.d.a) but there is currently no requirement that shelters must be certified to operate.

Additionally, it's important to note that eight of the participants felt that living in domestic violence or family shelters contributed to their child's behaviors in a negative manner. The perceptions of the mother's that shelter living contributed to their children's problems socially, emotionally and behaviorally were consistent with the findings in the literature for homeless children (Murphy & Tobin, 2011; University of Pittsburgh Office

of Child Development, 2010). However, the literature on IPV-exposed children's increased social, behavioral and emotional impact due to unstable housing is limited (Aymer, 2008) so the findings from this study may have ramifications for extending the knowledge in the discipline.

Theme 8: For some mothers, the perpetrators had discovered where they lived and had threatened them.

All of the women experienced going into hiding post-separation by living in domestic violence, or family shelters with their children and four of them were living in fear because the perpetrator had discovered where they lived and had threatened them. The safety of the participants was already compromised when they initially left the abusive relationship which is consistent with the literature which states that women are at greatest risk for retaliation including femicide postseparation (Sheehan, Murphy, Moynihan, Dudley-Fennessey, & Stapleton, 2014;
WHO, n.d.).

Additionally, the mothers voiced fear and emotional instability which has also been cited in the literature when victims of IPV are stalked by their perpetrators postseparation (Edwards & Gidycz, 2014).

Theme 9: Many of the mothers had experienced trauma and parental substance use during their childhood.

A ninth theme identified which related to RQ1 was the mother's childhood experiences. Six of the nine participants were exposed to IPV as children and most of those who were exposed to IPV were also physically or sexually abused. Thus, for the

study participants, the study rate exceeded what has been reported in the literature on IPV-exposed children and the co-occurrence of abuse, maltreatment, and neglect (Edleson, 1999b). Among the majority of the mothers (*n = 6*), their childhood experiences also included parental substance abuse which co-occurred with their exposure to IPV (except for one participant). The challenges they encountered due to their childhood experiences were substantiated in the literature (CDC, 2016; NCCEDV, 2006; Velleman & Templeton, 2007).

Theme 10: Many of the mothers had family responsibilities at a young age, became pregnant during their teenage years and dropped out of school.

Several of the mothers described that they were caretakers to their siblings or had other family obligations at a young age. The findings are consistent with the literature which reflects that during adolescence, family obligations combined with other risk factors such as low-income or adverse childhood experiences, can lead to depression and PTSD symptomatology (Milan & Wortel, 2015). Additionally, consistent with the findings of this study, high family obligations also resulted in insecurities (Milan & Wortel, 2015) which Milan, Zona and Snow (2013) have linked to internalization in adolescent girls and vulnerable behaviors. Also, some of the mothers described acting out, being IPV victims as teenagers, and getting pregnant at a young age which resulted in their dropping out of school. These findings are also consistent with the literature on the impact that child IPV exposure and abuse can have throughout the lifespan (Felitti et al., 1998; Goddard & Bedi, 2010).

Theme 11: All of the mothers felt that family unity was important to them.

Two of the participants were born and raised in Puerto Rico and had migrated to the United States to separate from their abusers with their children. The remaining seven participants were second-generation Puerto Ricans who were born and raised in New York. All of the mothers spoke about their cultural roots with pride and described the values of familism with regards to communication, sharing, respect, and unity which confirms their collectivist cultural norms as Puerto Rican's (Mogro-Wilson, 2013; Yoshioka & Choi, 2005).

Theme 12: Many of the mothers were warned by their family members about their ex-partner.

For some of the participants, family relations were estranged either because they didn't heed the warnings against the perpetrator, some family members didn't agree with their separation, isolation occurred as a result of the IPV, or because they felt a need to protect their family from possible perpetrator retaliation postseparation. The findings are consistent with the cycle of abuse and the socially covert or overt ascribed roles of honor cultures as noted in the literature (Dietrich & Schuett, 2013; Mogro-Wilson, 2013; Umaña-Taylor & Yazedjian, 2006; WHO, 2014).

Theme 13: All stayed in the relationship because they wanted to keep the family unit together.

Another value that was described by the participants was marianismo. All of the participants emphatically described their roles as being dedicated to protecting their children (Mogro-Wilson, 2013). They discussed that their tolerance of the IPV was

highly related to providing their children with a two-parent family household. These findings are consistent with the literature which reflects that the collectivist cultural norms and beliefs of Puerto Rican mothers to maintain the family unit may make them more tolerable of IPV (Aymer, 2008; Dietrich & Schuett, 2013).

Theme 14: The majority of mother's left because they feared for their lives or because of the effects on their children.

The escalating severity of IPV and the realization that it was affecting their children was what made them leave the relationship which is also consistent with the literature (Nouer et al., 2014). In their study, Nouer et al. (2014) and Kelly (2009) found that socially supported mothers with children living in the home were more likely to leave their batterers.

Theme 15: All of the mothers blamed themselves for their children's IPV exposure.

Self-blame for having stayed in the relationship and the impact that IPV exposure has had on their children was evident among all of the mothers in this study. These findings are consistent with the values of marianismo which is an ascribed caring trait where mothers take on the role of protecting their children from harm (Fine et al., 2006). It's important to note that self-blame is a sign of maternal protectiveness but it doesn't take into account the actions of the perpetrator (Moulding, Buchanan, & Wendt, 2015).

Theme 16: All of the mothers were committed to protecting and making their children a priority.

All of the mothers verbalized that they were committed to doing whatever it took to get their children out of the situation they were in. They noted that their commitment

stemmed from the values of marianismo, self-blame and seeing the effects that IPV exposure had on their children. The commitment of the mothers to protect and make amends for the IPV is consistent with the literature (McDonald & Dickerson, 2013; Moulding et al., 2015) and may aid in promoting the IPV-exposed child's resilience due to periods of positive emotion (Obradovíc, 2012).

Theme 17: Several of the mothers taught their children life skills.

Among the participants who had adverse childhood experiences, they verbalized that they taught their children how to dial 911, their daughters not to sit on a man's lap, how to cook and clean, and how to wash their clothes and dress appropriately. The literature supports that mothers who have had adverse experiences may find it important to teach their children valuable life skills (Ahrens et al., 2010).

Theme 18: All of the mothers discussed goals for themselves or their children to have a better life.

All of the mothers discussed how they wanted their children to finish school, go to college and become professionals. Several of the mothers also described how they wanted to finish school and attain careers. Setting immediate or future goals has been linked to enhanced self-efficacy, models of empowerment (Cattaneo & Goodman, 2015), embracing independence (McDonald & Dickerson, 2013), and hope which is a part of healing (Arian, 2013).

Theme 19: Several of the mothers passed on Puerto Rican values and traditions with their children.

Several of the mothers discussed their roles of instilling the family values of respect and upholding the traditions of the Puerto Rican culture which included the language, music, and dances (Dietrich & Schuett, 2013). These findings are supported by Diaz Soto (1982) who notes that third generation Puerto Rican's have a tendency to adopt selective traditional traits as they become more acculturated in the United States.

Theme 20: All of the mother's had one or more sources of external support.

Post-separation counseling played a significant role in the mother's adjustment and was also voiced as an informative resource by all of them. In the shelter and after transitioning into apartments, the majority of the mother's continued counseling. The finding that all of the participants sought counseling contradicts what is found in the literature among Puerto Rican's because discussing one's issues with outsiders is not condoned (Dietrich & Schuett, 2013). However, the fact that the participants had already separated from their ex-partners sought help and had IPV-exposed children may have played a role in their level of readiness to discuss the IPV with professionals (Randell et al., 2012).

In addition to counseling, some of the participants discussed their relations with family members, friends, and new intimate relationships as being supportive. They spoke of the support they received emotionally, financially and with child-rearing. With regards to the community, it was perceived by most of the participants as supportive particularly for their children. Though the mothers kept to themselves, a few of them had formed

relationships with some community members who would look out for their children. Other participants discussed their faith, going to church and members of the church community as networks that were socially supportive. The effects of positive maternal social support in decreasing stress, promoting bonding and enhancing child resiliency has been well documented in the literature (Gewirtz & Edleson, 2007; Graham-Bermann et al., 2009; Kelly, 2009).

Only a few of the mothers felt that the community was a source of social support. The findings that only four of the mother's perceived the community as a source of support was not surprising for various reasons. All of the participants lived in underprivileged communities where social neighborhood disorders were prominent. Furthermore, three of the participants were living in fear of retaliation so they isolated themselves from the community. And, one participant had recently migrated to New York from Puerto Rico to escape her ex-partner and had not acculturated to the individualistic norms inherent in Americans (Diaz Soto, 1982; Gillette, 2011). Also, the overall findings that unsafe neighborhoods may further isolate and contribute to the insecurities of individuals who have experienced IPV are supported in the literature (Gracia & Herrero, 2016). However, in this study it's also important to note that participant identified community factors such as crime, poverty, and housing may act as risk factors that may negatively influence an IPV-exposed child (Aymer, 2008) but resilience can be directly or indirectly mediated by protective factors across various levels (Masten, 1994, 2014).

Theme 21: Most of the mothers had challenges navigating the system.

For the majority of the mothers, separating from the abuser was their first encounter with domestic violence organizations, shelters, ACS, or the legal system. However, all of them verbalized challenges dealing with the system. Social support received by the system (shelters, domestic violence organizations, ACS, and the legal system) were expressed with mixed reactions. As mentioned previously, except for two of the participants, none of them had dealt with the system before the separation, and most of them had challenges navigating it initially and on an ongoing basis. They all spoke highly of the help they received from community-based domestic violence organizations. They voiced that the domestic violence agency staff were dedicated advocates who accompanied them to court, helped them complete applications for TANF, SNAP, attain orders of protection, and were available to meet with them on a regular basis when needed. One participant discussed that she had an assigned detective, who was a domestic violence expert, who made home visits and was also very supportive. For some, mother-blaming was an issue they encountered post-separation with the legal system. Mother-blaming has been associated with mandatory reporting procedures and the individualist expectations of the legal system that may conflict with the religious and cultural beliefs of Puerto Rican mothers (Alaggia et al., 2015). Thus, the legal system findings were consistent with the literature because it doesn't take into account the emotional turmoil and traumatic experiences the mothers have endured as a result of the IPV (Alaggia et al., 2015).

A new finding which has implications for practice was that the majority of the participants perceived that most individuals who work for the legal system are unsympathetic to their needs and the needs of their children. Another finding in this study which was voiced by most of the participants that have implications for practice, related to the lack of bilingual employees in the system. Recruiting bilingual staff is vital because the Hispanic population is growing and they should have equal access to services even if they have limited English language proficiency. Caregiver support and culturally appropriate interventions, including education, have been identified as the key to strengthening mother-child relationships and the security of the child which promotes their resilience (Howell et al., 2010; NCCDEV, 2006; Randell et al., 2012).

Theme 22: Many of the mother's described challenges trusting others.

Despite having some external support resources, the trauma from the IPV experiences, also made most of the participants feel isolated because they had challenges forming new relationships due to lack of trust or fear. Some of them had been betrayed by family members and felt the need to avoid possible perpetrator retaliation with newly established friendships. These findings are consistent with the literature which reflects that traumatic experiences, such as IPV, are viewed as a violation of trust and building social networks is influenced by the individual's adjustment, self-esteem and the reactions of others (Trotter & Allen, 2009). Shame and self-blame may also manifest as avoidance, which has been associated with PTSD, and may be considered a conscious or unconscious self-protective mechanism (La Bash & Papa, 2013).

Theme 23: A few mothers learned positive lessons from the system.

Several of the mothers described how they learned about their rights either while in the shelter, from case workers or through counseling sessions. One mother discussed how she advocated to keep her daughter in the same school despite having to relocate to different shelters throughout New York City. Another verbalized that she used legal court proceedings to remove the rights of her perpetrator for child visitation, a third women described how she received assistance for her child who had autism. The findings in this study are consistent with the literature that mothers may have favorable outcomes when they're educated on their rights and are empowered to seek help (Cattaneo & Goodman, 2015; Calton, Grossman & Cattaneo, 2015; Letourneau, Duffy, & Duffett-Leger, 2012).

Theme 24: Despite separation, many of the mothers had emotional, mental health and physical conditions.

In this study, the findings indicated that the majority of the participants (n=7) had a range of emotional, psychological and physical health issues which have been associated with IPV. The symptomatology associated with IPV may manifest in the form of physical or psychological ailments including phobias (Black, 2011; Karakurt et al., 2014). Despite all of the participants having separated from their ex-partners, they all expressed a range of ongoing emotions which included fear, sadness, stress, shame, and frustration. Many authors have noted that IPV has long lasting injurious effects that continue postseparation (Alejo, 2014; Karakurt et al., 2014; Letourneau et al., 2013).

Theme 25: Several of the mothers had developed positive coping mechanisms.

The coping capabilities of the Puerto Rican mother's in this study varied, but several of them had found constructive outlets for managing stressful situations. For most of them, spending time with their children, family, and friends provided them with some peace of mind. Others reported self-imposed timeouts, prayer and going to church as outlets when they felt stressed. The findings on the mother's use of primarily their children and social connections as coping mechanisms are consistent with the literature (Letourneau et al., 2013; Muller, Goebel-Fabbri, & Diamond, 2000).

Research Question 2 Themes

What are the perceptions of Puerto Rican mothers who are victims of IPV on how exposure to IPV has influenced their children aged 6-11 years? Twenty-five themes were identified for the second research question. No kids attended or were interviewed during this study. The theme will be addressed only for the children who met the study's criteria of being aged 6 to 11 years and were exposed to IPV. In total, the number of IPV-exposed children who met the criteria equated to 12 children among the nine participants.

Theme 26: Many of the children were exposed to verbal and physical IPV in utero and at an early age.

The first theme identified for RQ 2, child exposure, related to the types of IPV that the children, aged 6 to 11 years, were exposed to as perceived by the Puerto Rican mothers who participated in this study. Among the biological mothers ($n = 8$), the majority ($n = 6$) reported that they were pregnant and that a total of seven children were exposed to IPV in utero more than once. The mother's reported that their children were

exposed to multiple overlapping episodes of verbal, physical and sexual abuse in utero. For example, all of the mothers reported verbal abuse during their pregnancies, four reported physical abuse and one reported sexual abuse respectively. Additionally, the majority of the mothers (*n = 8*) stated that their IPV-exposed children were direct witnesses to numerous verbal and physical incidents of IPV throughout their lifetime. Thus, the children also heard it and experienced its after-effects. Children can be exposed to IPV in a multitude of ways (Holden, 2003). However, the findings in this study indicated that directly witnessing the IPV was the most frequent type of exposure which is consistent with the literature (Hamby et al., 2011). Additionally, the findings that child IPV exposure occurred primarily in single female headed households and cohabitating mothers who were never married is also supported in the literature (Zill, 2015).

Theme 27: Most of the mother's described that their children were old enough to understand.

The majority of the mothers described that their children were old enough to understand the IPV that was occurring in their homes but one participant, whose daughter was born with developmental problems perceived that her daughter wasn't old enough to understand. The literature reflects that IPV affects children as early as in utero (Bell et al., 2009) and that younger children may not be able to talk about it but are aware of their environment (Thornton, 2014).

Theme 28: Fear, anger, internalizing and externalizing behaviors were common in the children.

The study participants verbalized that their IPV-exposed children aged 6 to 11 years had a range of responses immediately, during and after the IPV incidents. Most of the mothers who were abused while pregnant (*n = 6*) also reported that their children were born premature, with small birthweight, developmentally delayed, and one was born anxious at birth which are findings that are supported in the literature. Additionally, all of the participants reported overlapping child responses during IPV incidents which included fear (*n = 9*), intervening (*n = 6*), victimization durng IPV incidents (*n = 3*), shock (*n = 4*), crying (*n = 3*), hiding (*n = 2*), and screaming or yelling (*n = 4*). Six mothers described multiple physical IPV incidents where their children intervened and three of them verbalized that their children were verbally or physically victimized by the perpetrator. The literature supports that children who intervene place themselves at high levels of risk for child abuse and maltreatment (Edleson et al., 2003).

Also, the majority of the mothers reported various overlapping behaviors in their children aged 6 to 11 years post IPV exposure which included regression, being bullied, anger, bullying, and aggression. The aggressive behaviors were primarily directed towards other children in school or their siblings but in one case, the mother reported that her 11-year-old daughter was verbally aggressive towards her. The finding of aggressive behaviors by IPV-exposed children towards the mothers was noted by Izaguirre and Calvete (2015) in their qualitative study in Spain. Furthermore, ongoing internalizing and externalizing behaviors which the mother's perceived were associated with their

children's IPV exposure were reported by most of the mothers despite their separation from the perpetrator. The findings of behaviors associated with externalization and internalization are consistent with the literature on IPV-exposed children (Bell et al., 2009; McCaw et al., 2007; Yates et al., 2003).

Theme 29: Many of the children showed caring towards their mothers post IPV incidents.

It is also important to note that all of the mother's perceived their children as being mutually protective and supportive towards them. Some author's view this phenomenon as children taking on adult roles (Holt, Buckley, & Whelan, 2008; Katz, 2015) based on a normal childhood trajectory (Burman, 2008) but that notion has been challenged in the literature on young carers (O'Dell, Crafter, de Abreu, & Cline, 2010). In fact, IPV-exposed children may use caring as a coping mechanism (Callaghan, Alexander, Fellin, & Sixsmith, 2015; Fine, 1992) which appears to be the consistent with the findings in this study. Thus, the findings in this study was that the actions taken by the children to comfort and protect the mothers was perceived as being comforting and further strengthened the mother-child bond. The finding has ramifications for future research on how children show empathy towards the afflicted parent, how it's perceived by both parties, and whether it has the potential to strengthen the mother-child relationship which is integral to building resilience.

Theme 30: Some of the children had continued instability postseparartion.

Some of the mothers reported that their children had continued instability postseparation. Among them, the continued instability was attributed to being in foster

care environments and setbacks due to fear of retaliation from the perpetrator and housing challenges. The findings that the children in crisis were unstable are consistent with the literature that high stress levels influence the coping responses of children (Bai & Repetti, 2015).

Theme 31: Improvement in academic performance were evident among the IPV-exposed children.

Additionally, in terms of school performance, three of the mother's reported that their children's grades had improved, three of them felt that their kid's grades were good, and three stated that their kid's academic performance was excellent. The findings that the mother's perceived that their children were improving or excelling academically may provide a glimpse of their intellectual capacity which may serve as a protective factor (Gewirtz & Edleson, 2007; Masten, 2001). Forty-four percent of the mother's (*n = 4*) verbalized that their children were in special education classes and one of them attributed the child's academic challenges to the IPV-exposure. Among parents with more than one child aged 6 to 11 years, each child's school performance was discussed separately. The literature reflects that IPV-exposed children have had consistent lower rates of academic achievement in math and reading than non-IPV exposed or children with combined child maltreatment and IPV-exposure (Izaguirre and Cater, 2015; Kiesel, Piescher, & Edleson, 2016). Also, almost one-half of the mothers (*n = 4*) verbalized that postseparation they noticed their children were aggressive in school and two of them also reported that their child repeated grades due to difficulty concentrating and these findings are also consistent with the literature (Izaguirre & Cater, 2016).

Theme 32: Postseparation the children were mostly showing signs of coping, an internal asset.

All of the mothers felt that the coping skills of their children had improved postseparation once they were in stable environments. However, most of them felt that the healing was still in progress and age-appropriate problem solving skills were verbalized by the majority of the mothers. Many of them discussed how their children had tried to de-escalate IPV incidents by communicating with the perpetrator, were sleeping better now, or would ask questions. Despite some of the mothers having verbalized that their children had experienced developmental challenges postseparation, the majority of them perceived that their children had made significant progress and were advocates in getting them the help they needed. Also, it's important to note that among the participants ($n = 2$) who reported developmental milestone delays the children had underlying medical conditions which could influence language and motor skill delays or could have been exacerbated by IPV exposure. The findings that children were completing most tasks based on their developmental stage is in synch with their use of self-regulatory processes which are viewed as internal assets which impact resiliency in the literature (Gillespie et al., 2007; Khanlou & Wray, 2014; Masten, 2007).

Theme 33: Most of the children depicted actions of being responsible, trusting and hope.

Many of the mother's perceived that their children exhibited caring behaviors towards others including their siblings. The caring behaviors that children engaged in are consistent with the literature which attributed caring relationships to familismo as a

protective factor (Aysa-Lastra et al., 2012). The developmental accomplishments of the children discussed by the mothers may provide the kids with hope that they can reach their goals and may compensate for their exposure to adverse experiences such as IPV and are consistent with the literature (Martinez-Torteya et al., 2009). Additionally, the findings that the mothers went to great lengths to establish trust by providing examples of the steps they took to make their children feel safe, secure and resolve conflicts may also act as a protective factor for some children exposed to IPV and were associated with contributing to resiliency (Stephens, 2010).

Theme 34: Some of the children had health issues which they were being treated for.

The health of the children in this study varied. The majority of the mother's reported that their children had health issues which were being medically treated. Two mothers discussed that their children had ADHD/PTSD and were under medical supervision. One of the mother's attributed her son's ADHD/ PTSD to the IPV but, there was one discrepant case where the mother perceived her children's ADHD/PTSD was due to having lived in numerous shelters over a five-year timeframe and foster care placement. This finding may provide evidence of other factors that may have some impact on the issue. The findings of the study are supported in the literature which reflected that IPV-exposed children have different mental health needs even when they're exposed in utero (Bezruchka, 2005; Olaya et al., 2010).

Theme 35: At some point, all of the children had a symptom associated with PTSD.

Another important finding in this study, is that all of the mother's reported that their children had one or more re-experiencing, arousal and reactivity, or mood symptoms

associated with PTSD but the literature reflects that children don't typically fit the full criteria required for PTSD diagnosis specified in the Fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013; Levendosky et al., 2013). PTSD symptoms can range from acute to chronic, vary from one individual to another and may dissipate once the child has been removed from the trauma (Levendosky et al., 2013) which appeared to be the case for some of the participants' children in this study. The dissipation of symptoms was reported by several of the mother's and also found to be consistent with the literature (APA, 2008; National Institute of Mental Health, n.d.). The findings may be an indication of emotion-regulation, prosocial skill development or other protective factors which can impact resiliency (Masten, 2001) despite exposure to IPV (APA, 2008; Howell et al., 2010).

Theme 36: The majority of the children received counseling postseparation and some have continued counseling.

Counseling appeared to provide the children with access to someone they could speak with freely and the mothers (*n = 4*), whose children were still receiving sessions, all verbalized positive changes in their child's behaviors after counseling sessions. The literature reports that professional counselors can have a significant role in helping IPV-exposed children talk about their feelings, change their perceptions of the conflicts, address feelings of self-blame, and decrease feelings of distress (Izaguirre & Cater, 2016). The evidence reveals that children who talk about the violence with supportive individuals have less behavioral challenges, lower rates of PTSD, and are less likely to

blame themselves (Graham-Bermann, Kulkarni & Kanukollu, 2011; Pernebo & Almqvist, 2014).

Theme 37: Several children interacted regularly with friends and school personnel.

In addition to the counseling, the majority of the mothers described that their children had supportive relationships with friends and school personnel which aligns with the development of social competency skills and prosocial behaviors that are supported in the literature as being promotive to resilience (Masten, 2001, 2007). Additionally, all of the mother's discussed that success in school was a top priority which they spoke to their children about frequently. Among children, aged 6-11 years, the literature reflects that having friends and supportive relationships with school personnel may moderate behavioral challenges and promote adaptation as well as cognitive abilities in children (Masten et al., 1999; Pernebo & Almqvist, 2014). At this age, children are developing their identities and engaged in building social networks. The findings that the most of the mother's perceived that their children interacted with peers and sought out school personnel for assistance will contribute to the emerging evidence that supportive peer relations may enhance social competence, conflict-resolution, self-efficacy, and communication skills which have been identified as protective factors in IPV-exposed children (Development Services Group, Inc., 2013; Izaguirre & Cater, 2016).

Theme 38: The mother-child relationship was perceived to be robust.

Additionally, all of the mother's discussed the relationships they had with their IPV-exposed children in a positive manner. Most of them ($n = 5$) perceived that their relationships were open, honest, trusting and that their children would speak to them

about the IPV or any other issues. They also discussed that they have spoken to their children about the IPV and many acknowledged their children's challenges with having been exposed to IPV. The high percentage of women who spoke to their children about the IPV in this study contradicts the existing research which leans towards reasons why mothers don't speak to their children about the incidents (Insetta et al., 2015). Many of the mothers discussed how they respectfully engaged their children in conversations and provided outlets for them by motivating them, providing rewards to reinforce good behaviors, playing with them, and engaging them in activities. All of the mothers were strong advocates for their children and assisted them with problem-solving. Furthermore, all of them discussed the attempts they made to set aside their own feelings and depict a positive attitude when they were in the presence of their kids despite their own challenges with dealing with their lived experiences. The impact that a positive mother-child relationship has on the child's resilience has been well documented in the literature (Khanlou & Wray, 2014; Masten, 2001, 2007; Miller-Graff, Cater, Howell, & Graham-Bermann, 2014). The literature also reflects that mothers whose children talk to them about the IPV have better emotional connections and are more likely to have signs of resilience (Izaguirre & Calvete, 2015; Newland, 2014).

Theme 39: Many of the children had close relationships with siblings, family figures and family members.

Relationships with siblings can also have a positive or negative impact on the IPV-exposed child's adjustment (Callaghan et al., 2015; Gass, Jenkins, & Dunn, 2007; Pike, Coldwell, & Dunn, 2005). Eight of the mothers verbalized that their children had

siblings. They verbalized that their other children had also been exposed to IPV either with the most recent perpetrator or in a previous relationship. Among the children, three mothers reported that their IPV-exposed children had older and younger siblings, one had a younger sibling, and four had older siblings. The IPV-exposed children's relationships with siblings, who had experienced the IPV in the household with the most recent perpetrator, were described by the participants as caring, protective and sometimes rivalrous. The findings of IPV-exposed children caring for and protecting each other adds to the literature that affectionate sibling relationships may have the potential to mediate child behavioral challenges over time caused by exposure to adverse events (Gass et al., 2007). Two of the participants whose children had siblings noted that their children had minimal relationships or no contact with some of their siblings who were older, had been raised by another caregiver and had not lived in the household where the most recent IPV had occurred. It appeared that when the relationships with the mother and her other children was estranged that the IPV-exposed children's relationships with their siblings was also affected if they weren't living in the home.

Family members, family figures and other adults can also be valuable sources of support for IPV-exposed children (Howell et al., 2014; Izaguirre & Cater, 2016). In this study, the majority of the mothers identified other family members or family figures as sources of support for themselves as well as their children which included grandmother's, nieces, cousins, foster parents, and new intimate partners. The mothers did not mention whether their child would talk about their experiences with these individuals but did say that their children had nurturing relationships with them and enjoyed spending time with

them. These findings are supported by the existing literature on the collectivist culture of Puerto Ricans and the values of familism (Mogro-Wilson, 2013). The literature also reflects the value that supportive and encouraging role models, outside of the family, can provide to IPV-exposed children ((Khanlou & Wray, 2014; Masten, 2007, 2014).

Theme 40: Some of the children confided in their sibling's about the IPV.

In the cases where the children did have relationships with their siblings who lived in the household during the IPV, some of the participants discussed that their kids talked to each other about the IPV incidents. Often times, the caring and protective role that children adopt with their mothers is also adopted with their siblings (Callaghan et al., 2015). Thus, in such cases, the literature reflects that it would not be unusual for siblings to not talk about the IPV because of their relational role as an empowered active protector and problem-solver who does not want to inflict damage (Callaghan et al., 2015). Yet, on the other hand, the literature reflects that some children are also empowered to talk about the IPV (Howell et al., 2014) but some children engage in self-preservation by keeping silent (Callaghan et al., 2015). Lastly, several of the mothers noted that the older children were the ones who were more likely to intervene which would agitate their younger kids into getting involved. These findings contribute to the limited literature that child adjustment may also be influenced by their relationships with their older siblings and the sibling's adjustment (Pike et al., 2005).

Theme 41: Some of the children were involved in extracurricular activities.

Involvement in extracurricular activities may also serve as external resources for IPV-exposed children. As for extracurricular activities, three of the nine participants had

their children involved in school, after-school, summer, or church related activities. The literature supports that involvement in extracurricular activities may mitigate cumulative risks such as exposure to IPV and promote adjustment (Aymer, 2008; Hardaway et al., 2012; Tiet et al., 2010). Thus, the finding that a small number of the participant's children were involved in extracurricular activities has implications for practice.

Theme 42: Most of the perpetrators were the biological fathers of the IPV-exposed children.

There are no universally identified characteristics or traits for men who are perpetrators of domestic violence (Mederos, n.d.). In this study, all of the perpetrators were males and this is consistent with the literature that males have a greater prevalence of perpetrating IPV against women than women do against men (Hamby et al., 2011). In this study, the majority of the mothers noted that the perpetrators were the biological fathers of the IPV-exposed children aged 6 to 11 years and one of the mother's reported having been married to the perpetrator. The findings that the majority of the children were exposed to IPV perpetrated by their biological fathers, who were primarily cohabitating partners of the mothers, are in synch with the NatSCEV data (Hamby et al., 2011) and survey data from the 2011-2012 National Survey of Children's Health (Zill, 2015).

Theme 43: Most of the perpetrators tried to control the children.

In some cases, the mother's discussed that the perpetrators had been controlling or abusive towards their children. According to the majority of the mothers, the perpetrators had demonstrated impatience, anger, aggressiveness, threatening, controlling, verbally, or

physically abusive behaviors towards their children. The literature reflects that fathers who physically abuse their children have lower levels of empathy and are over-sensitized to perceiving emotions in children as being angry or hostile (Francis & Wolfe, 2008). Additionally, fathers who perpetrate IPV may use the children to gain power and have poor father-child relations and parent-child boundaries due to their sense of entitlement and decreased abilities to deal with rejection (Meichenbaum, n.d.). It's important to note that despite these challenges, the strong mother-child bond described by the participants may act as a protective factor to the perpetrators actions towards the children (Masten & Reed, 2002).

Theme 44: Alcohol and illegal drug use by the perpetrator played a role in IPV for most of the participants.

Another finding in this study related to all of the participants having reported that their ex-partners drank alcohol and all, except for one, noted that their ex partners had also abused illegal drugs when they were in the relationship. IPV and substance abuse in parents has been attributed to child behavioral challenges and is well documented in the literature (Mogro-Wilson et al., 2013; Velleman & Templeton, 2007). However, in contrast to the findings by Mogro-Wilson et al. (2013) the mothers in this study did not report that their children were socially isolated when they were living with the perpetrator. In fact, a relevant finding in this study, which may contribute to the IPV-exposed child's resilience, was that the majority of the participants who reported substance abuse by their ex partners discussed how while they were in the relationship they had strong family ties which were supportive to their children. This finding of

having social supports is consistent with the literature which shows that social support networks may buffer the behavioral symptomatology of IPV-exposed children (Miller-Graff et al., 2014).

Theme 45: Most of the children don't have contact with the perpetrator.

Most of the mother's noted that their children didn't have any contact with the perpetrator. Among them, most perceived that their children harbored negative feelings toward the perpetrator which affected them socially and behaviorally and stated that their children did want to have contact with the perpetrator. One of them would consider supervised visitation if her daughter's father completed all of the court mandated programs. These findings are consistent with the literature that IPV-exposed children may fear or have ambivalent feelings towards the perpetrator (Holt et al., 2008; Shin, 2013).

Theme 46: A few children have or want contact with the perpetrator.

In this study, three of the perpetrators had contact with their children and one mother had revoked her ex partners rights to visitation. One of the mothers whose children had visitation stated that, in the beginning, her ex-parter would question the children and that they now hide things from him but enjoy spending time with him. The findings that children can have strong postseparation relationships with their fathers (Israel & Stover, 2009) are consistent with the literature. However, the relationships that children have with their fathers, as ex-perpetrators of IPV, may not be sources of social support for talking about the IPV incidents (Izaguirre & Cater, 2016).

Theme 47: The majority of the perpetrators don't have visitation or pay child support.

The majority of the mothers who had biological kids, aged 6 to 11 years, with the perpetrator did not receive child support. New York State has adopted the family violence option [FVO] and the New York State Welfare Reform Act of 1997 (1998) in response to the Personal Responsibility and Work Opportunity Act of 1996 (1996). Thus, in cases of domestic violence, victims are screened for domestic violence, provided with resources including emergency financial assistance and may be eligible for child custody waivers (New York State Office of the Prevention of Domestic Violence, n.d.b). Though most of the participants didn't elaborate on why they weren't receiving child support from the perpetrators who were living in the United States it's been documented that fear of retaliation may play a vital role in such decisions (Pearson, Thoennes & Griswold, 1998). Also, the Domestic Violence Program of the National Law Center on Homelessness and Poverty (2009) reported that, in New York, attaining a waiver is a screening process which requires the individual to self-disclose that they're an IPV victim in imminent danger and for a specialized Liaison to determine the credibility of the claim when the individual is applying for TANF benefits. The literature reflects low rates of waivers being granted and that New York, doesn't have uniform processes for IPV screenings, educating applicants on the FVO, or adequate caseworker training for granting waivers and making referrals (Hagen & Owens-Manley, 2002). Additionally, study findings indicate that caseworker biases and judgmental attitudes towards TANF applicants create

additional barriers to disclosure among battered women (Hagen & Owens-Manley, 2002; Saunders, Holter, Pahl, Tolman, & Kenna, 2016).

Theme 48: The mothers were empowered to help others by sharing some of their insights.

Several of the participants discussed that they had learned some valuable lessons about themselves and the IPV. They discussed the shared commonalities they found with other women who had IPV experiences which included the desire to be validated by their ex partners, having learned from their mistakes of choosing the wrong kind of men, the importance of knowing what resources are available, and leaving the relationship to save, not only their lives, but the lives of their children. In this study, the majority of the women had verbalized that their children provided a catalyst which prompted them to leave the relationship and this was consistent with Nouer et al. (2014) and Kelly (2009) who found that mothers, who were victims of domestic violence, and had children less than 18 years of age living in the home were more likely to separate from the batterer or seek help as a result of their roles.

Theme 49: Some of the mothers want transparency with IPV screening procedures.

Some of the mothers described that they felt judged, blamed for the IPV incidents and that they weren't believed when they were screened for IPV which is consistent with the literature (Saunders et al., 2016). Ahrens et al. (2010) described that self-blame, cultural norms and traditional gender ascribed roles may make identifying and disclosing IPV a challenge for Latina's. All of the mothers in the study blamed themselves for the impact that the IPV had on their children, were ashamed and had great concern for their

children which acted as additional barriers to disclosure that were consistent with the literature (Kelly, 2009; Lewis, West, Bautista, Greenberg, & Done-Perez, 2005). Additionally, several of the participants verbalized that they were not knowledgeable of the resources available to them which was also consistent with the literature (Rizo & Macy, 2011). In this study, the mothers recommended that victims may likely be truthful if they are educated on what will happen if they disclose IPV in advance and are questioned in a non-bias manner.

Theme 50: Most of the mothers provided feedback on resources that are lacking for themselves and their children.

Recommended resources were verbalized by all of the participants (n=8) who attended the second interview. The recommended resources included supportive services from shelters, bilingual counseling services, services from individuals who have lived experiences with domestic violence, community education on resources available to IPV victims and their children, skills training and job placement, and housing opportunities in safe neighborhoods. Additionally, one of the mothers expressed the need for evaluations and programs for IPV-exposed children and some of the mothers verbalized the need for non-domestic violence centered mother-child activities. The New York City Mayor's Office to Combat Domestic Violence (2017) Task Force conducted an evaluation of existing preventive and interventional programs, court system handing of IPV cases, and community organizations and recommended efforts to enhance the coordination and access to IPV resources in New York City. The Task Force recommendations included expanding preventive and interventional efforts for IPV-exposed children, improving

criminal justice system responses to IPV including prosecution of perpetrators, increased community education on culturally tailored approaches including bilingual counselors, improved access to housing, and maximizing coordination using standardized IPV measurements and reporting.

A new finding was that most of the mother's noted that having a domestic violence survivor mentor would have been helpful to them and their children because they had challenges with trust and speaking in group settings. The literature on domestic violence survivor mentoring programs is sparse. One study, which used a feminist framework and relational-cultural theory, focused on a university mentoring program for female survivors of IPV and abuse during childhood (Reilly & D'Amico, 2011). Their findings indicated that mentoring assisted with many aspects of healing particularly among women who had survived physical and sexual child abuse. The positive health, behavioral and motivational outcomes of community-based mentoring programs for children, young adults in higher education and adults in the workplace are well documented (Eby, Allen, Evans, Ng, & DuBois, 2008; McDaniel & Yarbrough, 2016). Thus, survivor-based IPV mentoring programs for victims and their families should be further researched as they may have implications for improving resilience in both the mother and the IPV-exposed child.

Limitations of the Study

Several limitations were noted in this study. All of the participants resided in a New York City community which had been deemed high-risk for IPV (DOHMH, 2008; Fernandez-Lanier & Gilmer, 2008). Also, the participant's all self-described themselves

as being Puerto Rican. The described limitations may limit the study finding's transferability and generalizability to other communities or ethnicities. However, I did successfully identify patterns which could be used as variables in a larger quantitative study which may lead to generalizable results (Creswell, 2013; Patton, 2015). I have also described the findings using rich-thick descriptions which will allow readers to determine their potential transferability in other settings (Miles et al., 2015; Patton, 2015). And, I provided a full description of the de-identified participants, setting, and processes used which will also permit comparability to other samples (Miles & Huberman, 1994).

Additionally, it's important to note that I used a purposive non-probability criterion sampling strategy to recruit participants who met the predefined criteria which may also influence transferability and generalizability. The study participants were Spanish or English speaking Puerto Rican mothers who had been victims of IPV and had IPV-exposed children aged 6 to 11 years. As noted in Chapters 1 and 3, the sampling method was used to elicit in-depth information from a smaller number of cases (Patton, 2015). The criterion sampling strategy aided in attaining information rich cases (Patton, 1990). It provided focus, and assisted in setting boundaries so that the most appropriate participants were defined (Miles et al., 2015) based on the phenomenon, research questions, theoretical framework, time, and resources (Creswell, 2013; Maxwell, 2005; RWJF, 2008). Thus, the utilization of a non-probability sampling method was deemed appropriate to describing the experiences of the participants in my study.

Another limitation related to the small sample size which may influence the quality and credibility of the findings. Several authors have recommended that the sample

size for phenomenological studies should not be larger than 10 (Miles et al., 2015; Dukes, 1984; Creswell, 2013). However, the principle of saturation was used to determine the actual sample size as the research emerged (Mason, 2010). Data saturation (Fusch & Ness, 2015) was achieved at the seventh interview, but two additional interviews were conducted as a means of validating the theory and saturation (Creswell, 2013).

Another limitation to credibility related to my being the sole researcher in this study. I conducted all of the interviews and transcribed the data. However, member checking reinforced credibility for 15 out of the 17 interviews. The verbatim interviews and preliminary themes were presented to eight of the nine participants during the second interview and six of the eight participants via email after their second interviews. All of the participants verified the data and preliminary themes without making any changes. Additionally, I used a research assistant who independently coded and thematically analyzed the 17 interviews and attained an interrater reliability Kappa coefficient of .902 and an agreement percentage of 99%. Also, researcher bias was minimized through self-reflective journaling which allowed me to bracket any presuppositions and by data triangulation.

Lastly, I assumed that the mothers would provide truthful responses during the interviews which would influence the quality of the research. Three domestic violence experts provided feedback on the semi-structured interview protocol, and I edited based on their feedback of the content including the tone, wording and topic alignment of the questions as they related to the phenomenon (Frankfort-Nachmias & Nachmias, 2008). The validated interview protocol consisted of open-ended questions which elicited

episodic memories, was used as a guide and provided flexibility for probing questions as needed. The interviews were collaborative, I remained nonjudgmental, empathetic and didn't offer any advice. I conducted the interviews in a private office at a location they were familiar with for 89% of the participants and in the home of one of the participants based on her preference. Based on the collection of the rich-thick data and detailed descriptions provided by the interviewees, I am confidently assuming that their responses were truthful.

Recommendations

This study is representative of evidence derived from Puerto Rican mothers who were victims of IPV and their perceptions of how it impacted their IPV-exposed children aged 6 to 11 years. It's based on the lived experiences of mothers who were battered by their intimate partners and their reality needs to be given attention. Fifty themes were presented as evidence; twenty-five for each of the research questions. The research focused on the essence of the phenomena as described by the mothers. The Puerto Rican mothers reported their stories of living through multiple types of IPV and the impact exposure had on their children.

Future Research

During this study, there were several recommendations for future research identified.

The first recommendation relates to the findings that the women in this study weren't routinely screened for IPV despite having had multiple health care provider encounters. The USPSTF (2013) recommendations are that symptomatic and

asymptomatic women of childbearing age should be routinely screened for IPV. However, in this study, only a few of the participants reported having been routinely screened by a health care provider and only one reported being truthful. Barriers to IPV screenings by health care providers (Sprague et al., 2012; Taft et al., 2013) and barriers to disclosure among Puerto Rican women (Ahrens et al., 2010; Dietrich & Schuett, 2013; Mogro-Wilson, 2013) are well documented but research on screening compliance rates, the identification of positive cases and referrals for interventions is sparse (O'Doherty et al., 2015). The study participants and their IPV exposed children were in the relationship with their batterer for a mean of 6.4 years (*SD* = 4.81) which is shorter than the reported average of 11 years (Triantafyllou et al., 2016). Certainly, it appears that there were missed opportunities for screenings and early interventions. Thus, I am recommending provider research and training for IPV screenings.

Another recommendation for future research related to the findings that post-separation options for these participants and their IPV-exposed children were sparse in terms of housing. In New York City, domestic violence shelters house residents for a maximum of 120 days and then they're relocated to family shelters. All of the mothers reported having to live in multiple unsafe shelters with their children. Moving from one location to another was extremely disruptive socially, academically, and medically for the mothers and their children. The participants reported staying in shelters for an average timeframe of six months but the longest stay was five years. The literature reflects that housing instability contributes to the social, mental health and behavioral challenges of potentially compromised IPV-exposed children and their mother's mental health status as

well as parenting (Aymer, 2008; Gewirtz, DeGarmo, Plowman, August, & Realmuto, 2009; Suglia, Duarte, & Sandel, 2011). In New York City, there are various types of domestic shelters such as shared facilities, single-unit self-contained environments, and host private home clusters which are overseen by non-profit organizations but are rare (New York State Office of Children Services, 2014). Rather than focus on the acute service needs of domestic violence victims and the current systems or lack thereof in place to meet their needs, researchers need to focus on the feasibility of services that address the long-term housing needs of IPV victims and their children. The Housing First program (Baker et al., 2010; Mbilinyi, 2015) which has been piloted in several states has shown some promising results and should be explored as a housing option in New York City.

Also, several of the mothers described caring actions taken by the children to comfort and reassure them post IPV incidents. For the mothers, their child's actions were perceived as being protective and they felt it strengthened the mother-child bond. Nonetheless, in the literature the child's actions to provide comfort are often described as taking on adult roles (Holt et al., 2008; Katz, 2015). Nonetheless, the finding has ramifications for future research on how children show empathy towards the victim, if the child's actions influence their resilience, and whether it has the potential to strengthen the mother-child relationship.

Furthermore, the recommendations by the mothers for mentoring programs by survivors of IPV should be further researched. The current literature on school and community-based mentoring programs for children have shown favorable outcomes as

have workplace mentoring programs for adults (Eby et al., 2008; McDaniel & Yarbrough, 2016). The New York City's Mayor's Office to Combat Domestic Violence (2017) Task Force has identified the need to strengthen communities to offer innovative culturally-sensitive programs. Thus, training actively involved IPV survivors as mentors may improve the engagement of victims, empower them, assist in providing early interventions, and can be a vital source of social support for the mothers and their IPV-exposed children.

Implications for Social Change

The study results can impact women who have been victims of IPV and their children. The Puerto Rican women in this study articulated the story of the lived experience of being a victim of IPV and a Puerto Rican mother of IPV-exposed children aged 6 to 11 years. Their voices provided compelling expressions of their lived experiences and their perceptions of how their IPV-exposed children were impacted by the battering they witnessed. Thus, the research study relates to a real world problem and has the potential to promote positive social change as well as advocacy (Laureate Education, 2015b). One implication for social change was the contribution this study made to the literature on Puerto Rican mothers who were victims of IPV and how they perceived it affected their children.

At an individual and family perspective, this research can impact positive social change by empowering mothers to change their help-seeking behaviors by disclosing IPV (Morse et al., 2012) for their sake and that of their children. In this study, all of the mothers identified that seeing the effects that the IPV was having on their children

eventually acted as a wake up call. They discussed that they were open to being screened for IPV by their healthcare providers as long as they were not hurried, judged and were informed of the procedures for referrals in advance. They also requested that their children receive referrals, without ACS involvement, if they disclosed child exposure. Additionally, it will enhance interdisciplinary communication, training, and collaboration for the early recognition of child IPV-exposure, culturally sensitive screening practices for mothers and the provision of needs-based referrals (Felitti et al., 1998; USPSTF, 2013).

In terms of the community, the evidence attained from this study can also impact social change by aiding in mobilizing developmentally as well as culturally appropriate, evidence-based programs, tailored to meet the needs of the target population (Laureate Education, Inc., 2015b). There's a growing need for evidence which can be used to develop culturally sensitive programs specific to diverse racially and ethnically populations (Gillum, 2008; Niolon et al., 2017). In this study, the participants requested services for their children that they felt were lacking and joint extracurricular programs that could normalize their re-entry into society postseparation.

Also, societal positive social changes that are consistent with this study include potentially increasing the allocation of housing resources for families affected by IPV. Factors which negatively impacted the Puerto Rican mothers and their children in this study were attributed to housing instability. Many of the participants verbalized the deplorable conditions of the shelters and the impact that being moved from one location to another had on their health as well as their children's. Decision-makers need to

recognize that housing instability contributes to negative health outcomes for mothers and their IPV-exposed children. Funding considerations should be provided to domestic violence programs which are survivor driven, community engaged, and provide flexibility with financial assistance.

Lastly, the utilization of resilience theory provides a social change application. Focusing on strengths rather than deficits could provide researchers opportunities to investigate outcomes that would promote the success of individuals who have had adverse experiences. Resilience theory could provide some insights into factors that are likely to help them improve their ability to adapt or bounce back from the challenges they have encountered. Resiliency is a nonlinear process of restoration which results from a combination of risks and protective factors and is an ordinary process which is an inherent human capability (Masten, 1994). Researchers could examine the combinations of risks and protective factors that make children and adults thrive despite exposure to negative experiences. In this study, interventions which include supportive individual, relationship and community responses to IPV have been identified. The implementation of one or more of my recommendations for research and practice can make a difference in the lives of Puerto Rican mothers who have been victims of IPV and their IPV-exposed children.

Practice Recommendations

There were also several interdisciplinary multilevel practice recommendations identified in this study. First, multilanguage and multimedia public educational campaigns should be launched to improve access to information and community

resources. IPV has no cultural or economical boundaries and victims need to be provided with the knowledge and tools they need to recognize IPV, seek assistance and make decisions (WHO, 2012). Such advertisements should be culturally sensitive, focus on all communities, provide information on the potential effects of child IPV-exposure throughout the lifespan, and interventions as well as consequences for batterers.

Also, other implications for practice derived from this study included the need for bilingual caseworkers, empathetic nonjudgmental individuals throughout the systems that victims of domestic violence encounter and recruitment and training of mentors (community health workers) who can support the mothers. The recommendation coincides with one of the ten essential services of public health which is to ensure that personnel are trained and that materials and staff are linguistically and culturally able to link individuals to the services they need (CDC, 2011).

Lastly, shelters, community domestic violence organizations and schools should be providing information on free or low-cost extracurricular activities for IPV-exposed children. Schools should engage the mothers to actively participate in school-related activities particularly since all of the study participants viewed their children's educational success as a top priority. Stress relieving activities for children which have been identified as protective include and aren't limited to exercise classes, sports, clubs, and summer camp programs (Social Impact Research, n.d.; The National Child Traumatic Stress Network, n.d.). Additionally, consideration should be given to activities or events that engage the mother and child as this may promote attachment and enhance resilience.

Summary and Conclusion

This qualitative phenomenological study was conducted to understand the lived experiences of Puerto Rican mothers who were subjected to IPV and their perceptions of the impact that it had on their IPV-exposed children. The Puerto Rican mothers who participated in this study endured an array of escalating IPV over time because they wanted to keep the family unit together but it affected their health, employment, and children in many ways which led to their separation from their partner. Despite the emotional, mental health and physical challenges associated with their IPV, they described positive coping mechanisms and ongoing counseling services for themselves and their children. Most of the mothers had had adverse childhood experiences themselves, family responsibilities at a young age, teenage pregnancies and had dropped out of school. They all expressed a strong affinity with the cultural values of familismo and marianismo and their commitment to supporting and, protecting their children and making a priority. Among the participants who had been employed many factors influenced their employment pre and postseparation, and all of them now relied primarily on state and disability benefits to support their families though this barely enabled them to make ends meet.

Most of the children were exposed to verbal and physical IPV in utero or at an early age and were old enough to understand. Since all of the mothers left their primary support systems during the study, the children were also exposed to life in shelters, which were not conductive to rearing them. The children exhibited a multitude of internalizing and externalizing behaviors as well as PTSD which most were being treated for and were

showing some signs of resilience based on their described internal assets and external resources.

A few of the mothers had had encounters with ACS and IPV screenings while they were in the relationship and post-separation and feared losing their children because of this. In three cases the children were removed from the home and placed in foster care or with other caregivers. Initially, the majority of the mothers had challenges navigating the system but a few learned some valuable lessons about their rights. They shared some of their insights and recommendations for services that would help other victims of IPV.

The majority of the perpetrators were the biological fathers of the children, drank alcohol or used illegal drugs, which exacerbated the IPV incidents, used controlling behaviors towards them, and didn't pay child support or have visitation. Most of the children harbored negative feelings towards the perpetrators but a few had contact or wanted to have contact with the perpetrator.

The results from the participant's stories provided insights into their struggles, the barriers they encountered and the actions they took to persevere postseparation from the perpetrator. Furthermore, the results also provided information on how they recognized the needs of their children, advocated for them and were committed to helping them overcome any negative impact that the IPV-exposure may have had. Their stories validated the importance of utilizing culturally sensitive approaches with victims of IPV as well as their IPV-exposed children and their desire that their voices for resource recommendations are heard and addressed. As a result of the voices of the participants, this study provided recommendations for future research and practice changes that may

empower others to seek help, reduce the impact of housing instability, and improve the health outcomes of mothers and their IPV-exposed children.

This study had some new and important findings in relation to the existing literature. Puerto Rican mothers are dedicated to their children and may not initially realize the impact that IPV-exposure has on them. The lower rates of IPV duration found among the participants and the need for transparency with IPV screening practices has implications for primary, secondary and tertiary prevention strategies. Such strategies should include goal setting as this provides hope and was viewed as empowering to the participants. Additionally, this study points to the need for bilingual workers, community engagement, and education to victims of IPV on navigating the system. There's also a need to explore how caring may strengthen the mother-child relationship and the added impact that unstable housing has on IPV-exposed children and their caregivers.

Ultimately, the voices and dedication of the participants can produce a ripple effect which would allow IPV-exposed children to become successful productive citizens. For me, the reflective insights gained from the research were profound and I'm committed to disseminating the valuable information that I derived from the study participants to domestic violence, community and health organizations.

References

Ahrens, C. E., Rios-Mandel, L. C., Isas, L., & del Carmen Lopez, M. (2010). Talking about interpersonal violence: Cultural influences on Latinas' identification and disclosure of sexual assault and intimate partner violence. *Psychological Trauma: Theory, Research, Practice, and Policy, 2*(4), 284-295. Doi:10.1037/a0018605

Alaggia, R., Gadalla, T. M., Shlonsky, A., Jenney, A., & Daciuk, J. (2015). Does differential response make a difference: examining domestic violence cases in child protection services. *Child & Family Social Work*, *20*(1), 83-95. doi:10.1111/cfs.12058

Alejo, K. (2014). Long-term physical and mental health effects of domestic violence. *Research Journal of Justice Studies and Forensic Science, 2*(1), 82-98. Retrieved from http://scholarworks.sjsu.edu/themis/vol2/iss1/5

Amanor-Boadu, Messing, J. T., Stith, S. M., Anderson, J. R., O'Sullivan, C. S., & Campbell, J. C. (2012). Immigrant and nonimmigrant women: Factors that predict leaving an abusive relationship. *Violence Against Women, 18*(5), 611-633. doi:10.1177/1077801212453139

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 377-402. Retrieved from http://www.apastyle.org/learn/

American Psychological Association. (2008). *Children and trauma: Update for mental health professionals*. Washington, DC: Author.

American Psychological Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Analytic Sciences, Inc. (2002). *Workshop on children exposed to violence: Current status, gaps, and research priorities*. Washington, DC: U. S. Department of Justice, National lnstitute of Justice & U.S. Department of Education, Office of Special Education Programs. Retrieved from http://www.nichd.nih.gov

Andrés-Hyman, R. C., Ortiz, J., Añez, L. M., Paris, M., & Davidson, L. (2006). Culture and clinical practice: Recommendations for working with Puerto Ricans and other Latinas(os) in the United States. *Professional Psychology Research and Practice, 37*(6), 694-701. doi:10.1037/0735-7028.37.6.694

Appel, A. E. & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology, 12*(4), 578-599. doi:10.1037/0893-3200.12.4.578

Arian, G. (2013). *Domestic violence survivors experiences of hope* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Accession Order No. 3602480).

Aymer, S. (2008). Adolescent males' coping responses to domestic violence: A qualitative study. *Children And Youth Services Review, 30*(6), 654-664. doi:10.1016/j.childyouth.2008.01.011

Aysa-Lastra, M., Rojas, P., Dillon, F., Duan, R., & De La Rosa, M. (2012). Family closeness and domestic abuse among caribbean and south american women in

south Florida. *Journal of Family Violence, 27*(6), 547-559. doi:10.1007/s10896-012-9445-1

Bai, S., & Repetti, R. L. (2015). Short-term resilience processes in the family. *Family Relations, 64*(1), 108-119. doi:10.1111/fare.12101

Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L**,** & Duggan, A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: A randomized, controlled trial of the Hawaii healthy start home visitation program. *Archives of Pediatrics and Adolescent Medicine, 164*(1), 16-23. doi:10.1001/archpediatrics.2009.237

Baker, C. K., Billhardt, K. A., Warren, J., Rollins, C., & Glass, N. E. (2010). Domestic violence, housing instability, and homelessness: A review of housing policies and program practices for meeting the needs of survivors. *Aggression and Violent Behavior, 15*, 430–439. doi:https://doi.org/10.1016/j.avb.2010.07.005

Ballif-Spanvill, B., Clayton, C. J., & Hendrix, S. B. (2007). Witness and nonwitness children's violent and peaceful behavior in different types of simulated conflict with peers. *American Journal of Orthopsychiatry*, *77*(2), 206–215. doi:10.1037/0002-9432.77.2.206

Barron, I. G., Miller, D. J., & Kelly, T. B. (2015). School-based child sexual abuse prevention programs: Moving toward resiliency-informed evaluation. *Journal of Child Sexual Abuse*, *24*(1), 77-96. doi:10.1080/10538712.2015.990175

Bassuk, E., Dawson, R., & Huntington, N. (2006). Intimate partner violence in extremely poor women: Longitudinal patterns and risk markers. *Journal of Family Violence, 21*(6), 387-399. doi:10.1007/s10896-006-9035-1

Bazeley, P. & Jackson, C. (2013). *Qualitative data analysis with NVivo* (2nd ed.) (pp.2-269). Los Angeles, CA: Sage Publications.

Beauchamp, R., Lindsay, S. P., Hunter, L. P., & Talavera, G. (2012). Patriarchal beliefs and attitudes toward intimate partner violence among Spanish-speaking adults. *Hispanic Health Care International, 10*(3), 137-164. doi:10.1891/1540-4153.10.3.137

Bell, M. E., Goodman, L. A. & Dutton, M. A. (2009). Variations in help-seeking, battered women's relationship course, emotional well-being, and experiences of abuse over time. *Psychology of Women Quarterly, 33*(2), 149–162. doi:10.1111/j.1471-6402.2009. 01485.x

Benavides, L. l. (2015). Protective factors in children and adolescents exposed to intimate partner violence: An empirical research review. *Child & Adolescent Social Work Journal, 32*(2), 93-107. doi:10.1007/s10560-014-0339-3

Bent-Goodley, T. B. (2008). Health disparities and violence against women: Why and how cultural and societal influences matter. *Trauma, Violence & Abuse, 8*(2), 90-104. doi:10.1177/1524838007301160

Bezruchka, S. (Producer). (2005). *From womb to tomb: The influence of early childhood on adult health* [Audio podcast]. Retrieved from http://www.alternativeradio.org/products/bezs002

Black, M. C. (2011). Intimate partner violence and adverse health consequences: Implications for clinicians. *American Journal of Lifestyle Medicine*, *5*(5), 428-439. doi:10.1177/1559827611410265

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., … Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Breiding, M. J., Basile, C. K., Smith, S. G., Black, M. C., & Mahendra, R. (2015). *Intimate partner violence surveillance uniform definitions and recommended data elements, Version* 2. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Brown, A. & Patten, E. (2016). Hispanics of Puerto Rican origin in the United States, 2011. Retrieved from http://www.pewhispanic.org/

Brown, M. J., Thacker, L. R., & Cohen, S. A. (2013). Association between adverse childhood experiences and diagnosis of cancer. *PLoS ONE*, *8*(6), e65524. doi:http://doi.org/10.1371/journal.pone.0065524

Bureau of Justice Statistics. (2012). Intimate partner violence. Retrieved July 6, 2014 from, http://bjs.ojp.usdoj.gov/content/pub/pdf/fvv.pdf

Burman, E. (2008). *Deconstructing developmental psychology* (2nd ed.). New York, NY: Routledge.

Callaghan, J. E. M., Alexander, J. H., Sixsmith, J., & Fellin, L. C. (2015). Children's experiences of domestic violence and abuse: Siblings' accounts of relational

coping. *Clinical Child Psychology and Psychiatry*, *21*(4), 649 – 668. doi:10.1177/1359104515620250

Calton, J. M., Grossman, J. L. & Cattaneo, L. B. (2015). The subjective court experiences of intimate partner violence victims: Does motherhood matter? *Journal of Interpersonal Violence*, 1-24. doi:10.1177/0886260515600166

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., & ... Laughon, K. (2003). Risk factors for femicide in abusive relationships: results from a multisite case control study. *American Journal of Public Health*, *93*(7), 1089-1097. doi:10.2105/AJPH.93.7.1089

Carlson, B. E. (2000). Children exposed to intimate partner violence: Research findings and implications for intervention. *Trauma, Violence, and Abuse*, *1*(4), 321- 340. doi:10.1177/1524838000001004002

Carrell, S., & Hoekstra, M. (2012). Family business or social problem? The cost of unreported domestic violence. *Journal of Policy Analysis and Management*, *31*(4), 861–875. doi:10.1002/pam.21650

Carrion, V. G., Weems, C. F., & Reiss, A. L. (2007). Stress predicts brain changes in children: A pilot longitudinal study on youth stress, post traumatic stress disorder, and the hippocampus. *Pediatrics, 119*(3), 509- 516. doi:10.1542/peds.2006-2028

Catalano, S., Smith, E., Snyder, H., & Rand, M. (2009). Female victims of violence. Bureau of Justice Statistics-NJC228356. Retrieved from http://www.bjs.gov/

Cattaneo, L. B. & Goodman, L. A. (2015). What is empowerment anyway? A model for domestic violence practice, research, and evaluation. *Psychology of Violence, 5*(1), 84-94. doi:http://dx.doi.org/10.1037/a0035137

Centers for Disease Control and Prevention. (n.d.). Promoting respectful, nonviolent intimate partner relationships through individual community, and societal change. Retrieved from http://www.cdc.gov

Centers for Disease Control & Prevention. (2003). Costs of intimate partner violence against women in the United States. Retrieved from http://www.cdc.gov/

Centers for Disease Control and Prevention. (2008). Intimate partner violence prevention scientific information: Risk and protective factors. Retrieved from http://www.cdc.gov/

Center for Disease Control & Prevention. (2010). Intimate partner violence in the United States- 2010. Retrieved from http://www.cdc.gov/

Centers for Disease Control & Prevention. (2011). Core functions of public health and how they relate to the 10 essential services. Retrieved from http://www.cdc.gov

Center for Disease Control & Prevention. (2014). *Intimate partner violence in the United States- 2010*. Atlanta, GA: Author.

Centers for Disease Control & Prevention. (2015a). Intimate partner violence: Risk and protective factors. Retrieved from http://www.cdc.gov/

Centers for Disease Control & Prevention. (2015b). The Social-ecological model: A framework for prevention. Retrieved from http://www.cdc.gov/

Centers for Disease Control and Prevention. (2016). Intimate partner violence: Definitions. Retrieved from http://www.cdc.gov

Centers for Disease Control and Prevention. (2017). The National Intimate Partner and Sexual Violence Survey. Retrieved from http://www.cdc.gov

Centers for Medicare and Medicaid Services. (2006). Glossary. Retrieved from https://www.cms.gov/

Centre for Research & Education on Violence against Women & Children (2010). Guidelines for safely leaving an abusive relationship. Retrieved from http://www.learningtoendabuse.ca/

Chan, Z. C.Y., Fung, Y. & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process? *Qualitative Report, 18*(59), 1-9. Retrieved from http://nsuworks.nova.edu/

Child Welfare Information Gateway. (2008). What is child abuse and neglect? Retrieved from http://www.childwelfare.gov/pubs/factsheets/whatiscan.pdf

Citizens Committee for Children of New York, Inc. (2015). CCC community risk ranking: Child well-being in New York City's 59 community districts. Retrieved from http://www.cccnewyork.org/

City-data.com. (2009). New York, New York (NY) income map, earnings map, and wages data. Retrieved from http://www.city-data.com/income/income-New-York-New-York.html

City-data.com. (2011). Mott Haven neighborhood in Bronx, New York (NY), 10451, 10456, 10455, 10454 detailed profile. Retrieved March 4, 2015 from, http://www.city-data.com/neighborhood/Mott-Haven-Bronx-NY.html

City of New York. (2016). About ACS. Retrieved from http://www1.nyc.gov/

CLRChoice, Inc. (2012). Bronx, NY 10451 Household income statistics. Retrieved from http://www.clrsearch.com/10451-Demographics/Household-Income

Colby, S. L. & Ortman, J. M. (2015). Projections of the size and composition of the U.S. population: 2014 to 2060. Retrieved from https://www.census.gov/

Collazo, S. G., Ryan, C. L., & Bauman, K. J. (2010). Profile of the Puerto Rican population in the United States and Puerto Rico: 2008. Retrieved from https://www.census.gov/

Coleman, J. & Howlett, H. (2011). Interviewing for domestic violence [Video file]. Retrieved from http://centervideo.forest.usf.edu/

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (Laureate Education, Inc., custom ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.) (pp. 1-268). Thousand Oaks, CA: Sage Publications.

Crimes Against Children Research Center. (n.d.). National survey of children's exposure to violence (NatSCEV). Retrieved from http://unh.edu/

Crowne, S. S., Juon, H., Ensminger, M., Burrell, L., McFarlane, E., & Duggan, A. (2011). Concurrent and long-term impact of intimate partner violence on

employment stability. *Journal of Interpersonal Violence, 26*(6), 1282–1304. doi:10.1177/0886260510368160

Dahlberg, L. L. & Krug, E. G. (2002). Violence-a global public health problem. In: Krug, E., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds). *World Report on Violence and Health* (pp. 1–56). Geneva, CH: World Health Organization.

DeBoard-Lucas, R., & Grych, J. (2011). Children's perceptions of intimate partner violence: Causes, consequences, and coping. *Journal of Family Violence, 26*(5), 343-354. doi:10.1007/s10896-011-9368-2

DeNavas-Walt, C. & Proctor, B. D. (2014). U.S. Census Bureau, Current population reports, P60-249, *Income and poverty in the United States: 2013*. Washington, DC: U.S. Government Printing Office. Retrieved from http://www.census.gov/

Development Services Group, Inc. (2013). *Protective factors for populations served by the Administration on Children, Youth, and Families: A literature review and theoretical framework*. Bethesda, MD: Author.

Diaz Soto, L. (1982). The Puerto Rican family: Tradition and the emergence of change. Marion, IN: Indiana Wesleyan Center for Educational Excellence. Retrieved from ERIC database. (ED229492)

Dietrich, D. M. & Schuett, J. M. (2013). Culture of honor and attitudes toward intimate partner violence in Latinos. *Sage Open*, 1-11. doi:10.1177/2158244013489685

Domestic Violence Program of the National Law Center on Homelessness & Poverty. (2009). Short changing survivors: The Family Violence Option for TANF benefits. Retrieved from http://www.ncdsv.org/

Dukes, S. (1984). Phenomenological methodology in the human sciences. *Journal of Religion and Health, 23*(3), 197–203. doi:10.1007/BF00990785

Durose, M. R., Harlow, C.W., Langan, P. A., Motivans, M., Rantala, R. R., & Smit, E. L. (2005). Family violence statistics: Including statistics on strangers and acquaintances (NCJ 207846). Retrieved from http://www.bjs.gov/content/pub/pdf/fvs02.pdf

Eby, L. T., Allen, T., Evans, S., Ng, T., & DuBois, D. (2008). Does mentoring matter? A multidisciplinary meta-analysis comparing mentored and non-mentored individuals. *Journal of Vocational Behavior, 72*, 254–267. doi:10.1016/j.jvb.2007.04.005

Edleson, J. L. (1999a). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14*(8), 839-870. doi:10.1177/088626099014008004

Edleson, J. L. (1999b). The overlap between child maltreatment and woman battering**.** *Violence Against Women, 5*(2), 134- 154. doi:10.1177/107780129952003

Edleson, J. L., Mbilinyi, L. F., Beeman, S. K., Hagemeister, A. K. (2003). How children are involved in adult domestic violence: Results from a four-city telephone survey. *Journal of Interpersonal Violence***,** *18*(1), 18- 32. doi:10.1177/0886260502238538

Edelson, M. G., Hokoda, A., & Ramos-Lira, L. (2007). Differences in effects of domestic violence between Latina and non-Latina women. *Journal of Family Violence, 22*(1), 1-10. doi:10.1007/s10896-006-9051-1

Edwards, K. M. & Gidycz, C. A. (2014). Stalking and psychosocial distress following the termination of an abusive dating relationship. *Violence Against Women*, *20*(11), 1383 – 1397. doi:10.1177/1077801214552911

Elliott, R. & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In J. Miles & P. Gilbert (Eds.). *A Handbook of Research Methods for Clinical and Health Psychology* (pp. 147- 159). New York: NY: Oxford University Press.

Englander, M. (2012). The interview: Data collection in descriptive phenomenological human scientific research. *Journal of Phenomenological Psychology, 43*(1), 13–35. doi:10.1163/156916212X632943

Erikson, E. H. (1993). *Childhood and society* (2nd Ed.). New York, NY: W. W. Norton.

Falk, G. (2014). Temporary Assistance for Needy Families (TANF): Eligibility and benefit amounts in State TANF cash assistance programs. Retrieved from https://fas.org/sgp/crs/misc/R43634.pdf

Family Violence Prevention and Services Act of 2003, 42 U.S.C. § 110- 306 et seq. (2003). Retrieved from http://www.govtrack.us/congress/billtext.xpd?bill=s108-342

Family Violence Prevention Fund. (2008). The facts on children and domestic violence. Retrieved from http://www.endabuse.org/

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse

childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245- 258. doi:http://dx.doi.org/10.1016/S0749-3797(98)00017-8

Fergus, S., & Zimmerman, M. (2005). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annual Review of Public Health*, 26, 399-419. doi:10.1146/annurev.publhealth.26.021304.144357

Fernandez-Lanier, A. & Gilmer, J. A. (2008). Domestic homicide in New York State, 2007. Retrieved from http://www.criminaljustice.ny.gov/

Fine, M. (1992). Coping with Rape: Critical perspectives on consciousness. In M. Fine (Ed.), *Disruptive Voices: The possibilities of feminist research* (pp. 61–76). Michigan: University of Michigan Press.

Fine, M., Roberts, R. A., & Weis, L. (2006). Puerto-Rican battered women redefining gender, sexuality, culture, violence, and resistance. In N. J. Sokoloff & C. Pratt (Eds.), *Domestic violence at the margins: Readings on race, class, gender, and culture* (pp.272-292). New Brunswick, NJ: Rutgers University Press.

Finkelhor, D. Turner, H., Ormrod, R., Hamby, S. & Kracke, K. (2009). Children's exposure to violence: A comprehensive national survey. Retrieved from https://www.ncjrs.gov/

Finkelhor, D., Turner, H., Shattuck, A., Hamby, S. & Kracke, K. (2015). Children's exposure to violence, crime, and abuse: An update. Retrieved from https://www.ojjdp.gov/

Flouri, E., Midouhas, E., Joshi, H., & Tzavidis, N. (2015). Emotional and behavioural resilience to multiple risk exposure in early life: The role of parenting. *European Child & Adolescent Psychiatry, 24*(7), 745-755. doi:10.1007/s00787-014-0619-7

Francis, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M., & Grimshaw, J. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology & Health, 25*(10), 1229-1245.doi: http://dx.doi.org/10.1080/08870440903194015

Francis, K. J. & Wolfe, D. A. (2008). Cognitive and emotional differences between abusive and non-abusive fathers. *Child Abuse & Neglect, 32*(12), 1127–1137. doi:10.1016/j.chiabu.2008.05.007

Frankfort-Nachmias, C., & Nachmias, D. (2008). *Research methods in the social sciences* (7th ed.) (pp. 162- 185). New York, NY: Worth.

Fusch, P. I. & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416. Retrieved from http://www.nova.edu/ssss/QR/QR20/9/fusch1.pdf

Futures Without Violence. (n.d.). The facts on children's exposure to intimate partner violence. Retrieved from https://www.futureswithoutviolence.org/

Galanti, G. (2003). The Hispanic family and male-female relationships: an overview. *Journal of Transcultural Nursing, 14*(3), 180-185. doi:10.1177/1043659603014003004

Garmezy, N. (1971). Vulnerability research and the issue of primary prevention. *The American Journal of Orthopsychiatry*, *41*(1), 101-116. doi:10.1111/j.1939-0025.1971.tb01111.x

Garmezy, N., Masten, A. S. & Tellegen, A. (1984). The study of stress and competence in children: A building block for developmental psychopathology. *Child Development*, *55*(1), 97-111. doi:10.2307/1129837

Gass, K., Jenkins, J., & Dunn, J. (2007). Are sibling relationships protective? A longitudinal study. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *48*(2), 167–75. doi:10.1111/j.1469-7610.2006.01699.x

Gentium Consulting. (n.d.). Ensuring quality in qualitative research. Retrieved October 20, 2016 from, http://www.gentium.ca/index/Ensuring_quality.html

Gewirtz, A. H. & Edleson, J. L. (2007). Young children's exposure to intimate partner violence: Towards a developmental risk and resilience framework for research and intervention. *Journal of Family Violence, 22*(3), 151–163. doi:10.1007/s10896-007-9065-3

Gewirtz, A. H., DeGarmo, D. S., Plowman, E. J., August, G., & Realmuto, G. (2009). Parenting, parental mental health, and child functioning in families residing in supportive housing. *American Journal of Orthopsychiatry, 79*(3), 336–347. doi:10.1037/a0016732

Ghali, S. B. (1982). Understanding Puerto Rican traditions. *Social Work, 27*(1), 98-102. DOI: https://doi.org/10.1093/sw/27.1.98

Gilbert, A. L., Bauer, N. S., Carroll, A. E. & Downs, S. M. (2013). Child exposure to parental violence and psychological distress associated with delayed milestones. *Pediatrics, 132*(6), e1577–e1583. doi:10.1542/peds.2013-1020

Gillespie, B. M., Chaboyer, W., & Wallis, M. (2007). Development of a theoretically derived model of resilience through concept analysis. *Contemporary Nurse, 25*(1-2), 124-135. doi:10.5555/conu.2007.25.1-2.124

Gillette, M. (2011). Traditional Latino values and domestic violence. Retrieved from http://www.latinodv.org/

Gillum, T. L. (2008). The benefits of a culturally specific intimate partner violence intervention for African American survivors. *Violence Against Women*, *14*(8), 917 – 943. doi:10.1177/1077801208321982

Gluckman, P., Hanson, M., & Mitchell, M. (2010). Developmental origins of health and disease: Reducing the burden of chronic disease in the next generation. *Genome Medicine, 2*(2), 14. Retrieved from http://genomemedicine.com/

Goddard, C. & Bedi, G. (2010). Intimate partner violence and child abuse: A child centered perspective. *Child Abuse Review*, *19*(1), 5- 20. doi:10.1002/car.1084

Gracia, E. & Herrero, J. (2016). Perceived neighborhood social disorder and attitudes toward reporting domestic violence against women. *Journal of Interpersonal Violence*, 22(6), 737 – 752. doi:10.1177/0886260507300755

Graham-Bermann, S. A., Gruber, G., Howell, K. H., & Girz, L. (2009). Factors discriminating among profiles of resilience and psychopathology in children

exposed to intimate partner violence (IPV). *Child Abuse & Neglect, 33*(9), 648-660. doi:10.1016/j.chiabu.2009.01.002

Graham-Bermann, S. A., Kulkarni, M.R. & Kanukollu, S. N. (2011). Is disclosure therapeutic for children following exposure to traumatic violence? *Journal of Interpersonal Violence, 26*(5), 1056-1076. doi:10.1177/0886260510365855

Graham-Bermann, S. A. & Perkins, S. Z. (2010). Effects of early exposure and lifetime exposure to intimate partner violence (IPV) on child adjustment. *Violence and Victims, 25*(4), 427-439. doi:10.1891/0886-6708.25.4.427

Greeson, M. R., Kennedy, A. C., Bybee, D. I., Beeble, M., Adams, A. E., & Sullivan, C. (2014). Beyond deficits: Intimate partner violence, maternal parenting, and child behavior over time. *American Journal of Community Psychology, 54*(1-2), 46-58. doi:10.1007/s10464-014-9658-y

Groves, B. M., Augustyn, M., Lee, D, & Sawires, P. (2004). Identifying and responding to domestic violence: Consensus recommendations for child and adolescent health. Retrieved from http://www.endabuse.org/

Hagemeister, A. (2000). Overlap of domestic violence and child maltreatment in U.S.A. State civil and criminal status. Retrieved from http://www.mincava.umn.edu/

Hagen, J. L., & Owens-Manley, J. (2002). Issues in implementing TANF in New York: the perspective of frontline workers. *Social Work*, *47*(2), 171-182. doi:https://doi.org/10.1093/sw/47.2.171

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally

representative survey of youth. *Child Abuse & Neglect*, *34*(10), 734-741. doi:10.1016/j.chiabu.2010.03.001

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). Children's exposure to intimate partner violence and other family violence. *Juvenile Justice Bulletin – NCJ 232272*. Washington, DC: U.S. Government Printing Office. Retrieved from https://www.ncjrs.gov/

Hardaway, C. R., McLoyd, V. C., & Wood, D. (2012). Exposure to violence and socioemotional adjustment in low-income youth: an examination of protective factors. *American Journal of Community Psychology*, *49*(1-2), 112-126. doi:10.1007/s10464-011-9440-3

Harrell, M. C. & Bradley, M. A. (2009). *Data collection methods: Semi-structured interviews and focus groups*. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/

Hartley, C. (2004). Severe domestic violence and child maltreatment: Considering child physical abuse, neglect, and failure to protect. *Children and Youth Services Review, 26*(4), 373–392. doi:10.1016/j.childyouth.2004.01.005

Head, S. K., Zweimueller, S., Marchena, C., & Hoel, E. (2014). *Women's lives and challenges: Equality and empowerment since 2000*. Rockville, MD: ICF International. National Center for Children Exposed to Domestic Violence. Retrieved from http://www.nccev.org/

Hegarty, K., O' Doherty, L., Taft, A., Chondros, P., Brown, S., Valpied, J., … Gunn, J. (2013). Screening and counseling in the primary care setting for women who have

experienced intimate partner violence (WEAVE): A cluster randomised controlled trial. *The Lancet, 382*(9888), 249-258. doi:10.1016/S0140-6736(13)60052-5

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women, 4*(3), 262-290. doi:10.1177/1077801298004003002

Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C., & Moylan, C. A. (2008). Intersection of child abuse and children's exposure to domestic violence. *Trauma Violence Abuse, 9*(2), 84-99. doi:10.1177/1524838008314797

Herrenkohl, T. I., Tajima, E. A., Whitney, S. D., & Huang, B. (2005). Protection against antisocial behavior in children exposed to physically abusive discipline. *Journal of Adolescent Health*, *36*(6), 457-465. doi:http://dx.doi.org/10.1016/j.jadohealth.2003.09.025

Holden, G.W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. *Clinical Child and Family Psychology Review, 6*(3), 151-160. doi:10.1023/A:1024906315255

Holt, S., Buckley, H. & Whelan, S. (2008). The impact of exposure to domestic violence on young people: A review of the literature. *Child Abuse and Neglect, 32*(8), 797-810. doi:http://dx.doi.org/10.1111/j.1365-2214.2008.00904_5.x

Holt-Lunstad, J. & Uchino, B. N. (2015). Social support and health. In K. Glanz, B. K. Rimer & K. Viswanath (Eds.), *Health behavior: Theory, research, and practice* (5th ed.) (pp. 183-204). San Francisco, CA: Jossey-Bass.

Howden, L.M. & Meyer, J. A. (2011). Age and sex composition: 2010. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. *Aggression & Violent Behavior, 16*(6), 562- 569. doi:10.1016/j.avb.2011.09.001

Howell, K., Cater, A., Miller-Graff, L., & Graham-Bermann, S. (2014). The process of reporting and receiving support following exposure to intimate partner violence during childhood. *Journal of Interpersonal Violence*, *30*(16), 2886-2907. doi:10.1177/0886260514554289

Howell, K. H., Graham-Bermann, S. A., Czyz, E., & Lilly, M. (2010). Assessing resilience in preschool children exposed to intimate partner violence. *Violence and Victims, 25*(2), 150-164. doi:10.1891/0886-6708.25.2.150

Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011). Overview of race and Hispanic origin: 2010 Census briefs. Retrieved from http://www.census.gov/

Huth-Bocks, A. C. *&* Hughes, H. M. (2008). Parenting stress, parenting behavior, and children's adjustment in families experiencing intimate partner violence. *Journal of Family Violence, 23*(4), 243–251. doi:10.1007/s10896-007-9148-1

Idemudia, E.S. & Makhubela, S. (2011). Gender difference, exposure to domestic violence and adolescents' identity development. *Gender and Behaviour, 9*(1), 3443-3465. doi:10.4314/gab.v9i1.67451

Insetta, E. R., Akers, A. Y., Miller, E., Yonas, M. A., Burke, J. G., Hintz, L., & Chang, J. C. (2015). Intimate partner violence victims as mothers: Their messages and strategies for communicating with children to break the cycle of violence. *Journal of*

Interpersonal Violence, 30(4), 703-724. doi:https://doi.org/10.1177/0886260514535264

Israel, E. & Stover, C. (2009). Psychological sequelae of witnessing intimate partner violence (IPV): The role of the child–perpetrator relationship. *Journal of Interpersonal Violence, 24*(10), 1755-1764. doi:10.1177/0886260509334044

Izaguirre, A. & Calvete, E. (2015). Children who are exposed to intimate partner violence: Interviewing mothers to understand its impact on children. *Child Abuse & Neglect, 48,* 58-67. doi:10.1016/j.chiabu.2015.05.002

Izaguirre, A. & Cater, A. (2016). Child witnesses to intimate partner violence: Their descriptions of talking to people about the violence. *Journal of Interpersonal Violence*. Advance online publication. doi:10.1177/0886260516639256

Jacob, S. A. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The Qualitative Report, 17*(6), 1-10. Retrieved from http://www.nova.edu/

Janesick, V. J. (2011). *"Stretching" exercises for qualitative researchers* (3rd ed.) (pp. 155-166). Thousand Oaks, CA: Sage Publications.

Karakurt, G., Smith, D., & Whiting, J. (2014). Impact of intimate partner violence on women's mental health. *Journal of Family Violence*, *29*(7), 693-702. doi:10.1007/s10896-014-9633-2

Katz, E. (2015). Domestic violence, children's agency and mother-child relationships: Towards a more advanced model. *Children & Society*, *29*(1), 69-79. doi:http://doi.org/10.1111/chso.12023

Kaufmann, K. G., Jasinski, J., & Aldarondo, E. (1994). Sociocultural status and incidence of marital violence in Hispanic families. *Violence and Victim, 9*(3), 207-222. Retrieved from http://www.springerpub.com/

Kelly, U. A. (2009). "I'm a mother first": The influence of mothering in the decision-making processes of battered immigrant Latino women. *Research in Nursing & Health, 32*(3), 286-297. doi:10.1002/nur.20327

Kelly, M. (2010). The role of theory in qualitative health research. *Family Practice, 27*(3), 285-290. doi:10.1093/fampra/cmp077

Kerig, P. K. (1998). Gender appraisals as mediators of adjustment in children exposed to interparental violence. *Journal of Family Violence, 13*(4), 345-363. doi:10.1023/A:1022871102437

Kernic, M. A., Wolf, M. E., Holt, V. L., McKnight, B., Huebner, C. E., & Rivara, F. P. (2003). Behavioral problems among children whose mothers are abused by an intimate partner. *Child Abuse & Neglect*, *27*(11), 1231-1246. doi:10.1016/j.chiabu.2002.12.001

Khanlou, N. & Wray, R. (2014). A whole community approach toward child and youth resilience promotion: A review of resilience literature. *International Journal of Mental Health and Addiction, 12*(1), 64-79. doi:10.1007/s11469-013-9470-1

Kiesel, L. R., Piescher, K. N., & Edleson, J. L. (2016). The relationship between child maltreatment, intimate partner violence exposure, and academic performance. *Journal of Public Child Welfare, 10*(4), 434-456. doi:10.1080/15548732.2016.1209150

Klevens, J., Kee, R., Trick, W., Garcia, D., Angulo, F. R., Jones, R., & Sadowski, L. S. (2012). Effect of screening for partner violence on women's quality of life. *Journal of the American Medical Association, 308*(7), 681-689. doi:10.1001/jama.2012.6434.

Kost, K. & Henshaw, S. (2014). U.S. teenage pregnancies, births and abortions, 2010: National and state trends by age, race and ethnicity. Retrieved from https://www.guttmacher.org/

Kramer, A., Lorenzon, D. & Mueller, G. (2004). Prevalence of intimate partner violence and health implications for women using the emergency departments and primary care clinics. *Womens Health Issues, 14*(1), 19-29. doi:10.1016/j.whi.2003.12.002

La Bash, H. & Papa, A. (2013). Shame and PTSD symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(2), 159. doi:10.1037/a0032637

Laureate Education, Inc. (Executive Producer). (2009). *Qualitative methods: Two examples* [Video file]. Baltimore: Author.

Laureate Education (Producer). (2015a). *Overview of the premise* [Video file]. Baltimore, MD: Author.

Laureate Education (Producer). (2015b). *Social impact of a dissertation* [Video file]. Baltimore, MD: Author.

Lester, S. (1999). *An introduction to phenomenological research.* Taunton, UK: Author. Retrieved from www.sld.demon.co.uk/resmethy.pdf

Letourneau, N., Duffy, L. & Duffett-Leger, L. (2012). Mothers affected by domestic violence: Intersections and opportunities with the justice system. *Journal of Family Violence, 27*(6), 585-596. doi:10.1007/s10896-012-9451-3

Letourneau, N., Morris, C. Y., Stewart, M., Hughes, J., Critchley, K. A., & Secco, L. (2013). Social support needs identified by mothers affected by intimate partner violence. *Journal of Interpersonal Violence, 28*(14), 2873-2893. doi:10.1177/0886260513488685

Levendosky, A. A., Bogat, G. A., Huth-Bocks, A. C., Rosenblum, K., & von Eye, A. (2011). The effects of domestic violence on the stability of attachment from infancy to preschool. *Journal of Clinical Child & Adolescent Psychology, 40*(3), 398-410. doi:10.1080/15374416.2011.563460

Levendosky, A. A., Leahy, K. L., Bogat, G., Davidson, W. S., & von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology*, *20*(4), 544-552. doi:10.1037/0893-3200.20.4.544

Levendosky, A. A., Bogat, G. A., & Martinez-Torteya, C. (2013). PTSD symptoms in young children exposed to intimate partner violence. *Violence Against Women, 19*(2), 187-201. doi:10.1177/1077801213476458

Lewis, M. J., West, B., Bautista, L., Greenberg, A. M., & Done-Perez, I. (2005). Perceptions of service providers and community members on intimate partner violence within a Latino community. *Health Education & Behavior, 32*(1), 69-83. doi:10.1177/1090198104269510

Liebschutz, J., Battaglia, T., Finley, E., & Averbuch, T. (2008). Disclosing intimate partner violence to health care clinicians - What a difference the setting makes: A qualitative study. *BMC Public Health, 8*, 229. doi:10.1186/1471-2458-8-229

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lofquist, D., Lugaila, T., O'Connell, M., & Feliz, S. (2012). Households and families: 2010. Retrieved from http://www.census.gov

Logan, T. K., Shannon, L., Cole, J., & Swanberg, J. (2007). Partner stalking and implications for women's employment. *Journal of Interpersonal Violence, 22*(3), 268-291. doi:10.1177/0886260506295380

Louis, M. S. & Johnson, E. J. (2017) How mothers perceive their own domestic violence victimization and how it impacts their children. *Journal of Child Custody, 14*(1), 34-48, doi:10.1080/15379418.2017.1314206

Martinez-Torteya, C., Bogat, G. A., von Eye, A., & Levendosky, A. A. (2009). Resilience among children exposed to domestic violence: The role of risk and protective factors. *Child Development, 80*(2), 562-577.doi:10.1111/j.1467-8624.2009.01279.x

Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *Forum: Qualitative Social Research*, *11*(3), 1-19. Retrieved from http://www.qualitative-research.net/index.php/fqs

Masten, A. S. (1994). Resilience in individual development: Successful adaptation despite risk and adversity. In M. C. Wang & E. W. Gordon (Eds.), *Education*

resilience in inner city America: Challenges and prospects (pp. 3-25). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Masten, A. S. (2001). Ordinary Magic: Resilience processes in development. *American Psychologist, 56*(3), 227-238. doi:10.1037//0003-066X.56.3.227

Masten, A. S. (2007). Resilience in developing systems: Progress and promise as the fourth wave rises. *Development and Psychopathology, 19*(3), 921-30. doi:10.1017/S0954579407000442

Masten, A. S. (2014). *Ordinary magic: Resilience in development*. New York, NY: The Guilford Press.

Masten, A., Best, K., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology, 2*, 425-444. doi:10.1017/S0954579400005812

Masten, A. S., Hubbard, J. J., Gest, S. D., Tellegen, A., Garmezy, N., & Ramirez, M. (1999). Competence in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology, 11*, 143-169. Retrieved from https://www.cambridge.org/

Masten, A. S., & Reed, M. J. (2002). Resilience in development. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 74-88). New York: Oxford University Press.

Max, W., Rice, D. P., Finkelstein, E., Bardwell, R. A., & Leadbetter, S. (2004). The economic toll of intimate partner violence against women in the united states. *Violence and Victims, 19*(3), 259-72. doi:10.1891/088667004780905660

Maxwell, J. A. (2005). *Applied Social Research Methods Series: Vol. 41. Qualitative research design: An interactive approach* (2nd ed.) (pp. 139-160). Thousand Oaks, CA: Sage Publications.

Mbilinyi, L. (2015). The Washington State domestic violence Housing First program. Retrieved from https://wscadv.org/

Mbilinyi, L. F., Edleson, J. L., Hagemeister, A. K. & Beeman, S. K. (2007). What happens to children when their mother's are battered? Results from a four city anonymous telephone survey. *Journal of Family Violence, 22*(5), 309-317. doi:10.1007/s10896-007-9087-x

McCaw, B., Golding, J. M., Farley, M., & Minkoff, J. R. (2007) Domestic violence and abuse, health status, and social functioning. *Women & Health, 45*(2), 1-23, doi:10.1300/J013v45n02_01

McDaniel, S., & Yarbrough, A. (2016). A literature review of afterschool mentoring programs for children at risk. *Journal of At-Risk Issues*, *19*(1), 1-9. Retrieved from http://dropoutprevention.org/

McDonald, P. & Dickerson, S. (2013). Engendering independence while living with purpose: Women's lives after leaving abusive intimate partners. *Journal of Nursing Scholarship, 45*(4), 388-96. doi:10.1111/jnu.12044

McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., & Green, C. E. (2006). Estimating the number of American children living in partner violent families. *Journal of Family Psychology, 20*(1), 137–142. doi:10.1037/0893-3200.20.1.137

Mederos, F. (n.d.). Accountability and connection with abusive men. Retrieved from http://www.futureswithoutviolence.org/

Meichenbaum, D. (n.d.). Family violence: Treatment of perpetrators and victims. Retrieved from https://www.melissainstitute.org/

Melbin, A., Jordan, A., & Smyth, K. F. (2014). *How do survivors define success? A new project to address an overlooked question*. Greenfield, MA: The Full Frame Initiative. Retrieved from http://www.blueshieldcafoundation.org/

Middlebrooks, J. S. & Audage, N. C. (2008). The effects of childhood stress on health across the lifespan. Retrieved from http://www.cdc.gov/

Milan, S., & Wortel, S. (2015). Family obligation values as a protective and vulnerability factor among low-income adolescent girls. *Journal of Youth & Adolescence, 44*(6), 1183-1193. doi:10.1007/s10964-014-0206-8

Milan, S., Zona, K., & Snow, S. (2013). Pathways to Adolescent Internalizing: Early Attachment Insecurity as a Lasting Source of Vulnerability. *Journal of Clinical Child & Adolescent Psychology*, *42*(3), 371-383. doi:10.1080/15374416.2012.736357

Miles, B., & Huberman, A. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Beverly Hills, CA: Sage.

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.) (pp. 20-25). Thousand Oaks, CA: Sage Publications.

Miller, E., Decker, M. R., Reed, E., Raj, A., Hathaway, J. E., Silverman, J. G. (2007). Male partner pregnancy-promoting behaviors and adolescent partner violence: Findings from a qualitative study with adolescent females. *Ambulatory Pediatrics, 7*(5), 360-366. doi:10.1016/j.ambp.2007.05.007

Miller, L. E., VanZomeren-Dohm, A., Howell, K. H., Hunter, E. C., & Graham-Bermann, S. A. (2014). In-home social networks and positive adjustment in children witnessing intimate partner violence. *Journal of Family Issues*, *35*(4), 462-480. doi:10.1177/0192513X13478597

Miller-Graff, L. E., Cater, Å., Howell, K. H., & Graham-Bermann, S. A. (2014). Perpetration patterns and environmental contexts of IPV in Sweden: Relationships with adult mental health. *International Journal of Child Abuse & Neglect, 38*(1), 147-158. doi:https://doi.org/10.1016/j.chiabu.2013.10.023

Mogro-Wilson, C. (2013). Parenting in Puerto Rican families. *Families in Society: The Journal of Contemporary Human Services, 94*(4), 235-241. doi:10.1606/1044-3894.4327

Mogro-Wilson, C., Negroni, L. K. & Hesselbrock, M. N. (2013). Puerto Rican parenting and acculturation in families experiencing substance use and intimate partner violence. *Journal of Social Work Practice in the Addictions, 13*(1), 50-69. doi:10.1080/1533256X.2012.756792

Moroz, K. J. (2005). The effects of psychological trauma on children and adolescents. Retrieved from http://mentalhealth.vermont.gov/

Morse, D. S., Lafleur, R., Fogarty, C. T., Mittal, M., & Cerulli, C. (2012). They told me to leave. *The Journal of the American Board of Family Medicine, 25*(3), 333-342. doi:10.3122/jabfm.2012.03.110193

Moulding, N., Buchanan, F., & Wendt, S. (2015). Untangling Self-Blame and Mother-Blame in Women's and children's perspectives on maternal protectiveness in domestic violence: Implications for practice. *Child Abuse Review*, *24*(4), 249-260. doi:10.1002/car.2389

Moustakas, C. (1994). *Phenomenological research methods* [electronic resource]. Thousand Oaks, CA: Sage Publications, Inc.

Mouter, N. & Vonk Noordegraaf, D. M. (2012). Intercoder reliability for qualitative research: You win some, but do you lose some as well? Retrieved from repository.tudelft.nl

Muller, R. T., Goebel-Fabbri, A. E., & Diamond, T. (2000). Social support and the relationship between family and community violence exposure and psychopathology among high risk adolescents. *Child Abuse & Neglect: The International Journal, 24*(4), 449-464. doi:10.1016/S0145-2134(00)00117-4

Murphy, J. T. & Tobin, K. F. (2011). Homelessness comes to school. *Phi Delta Kappan, 93*(3), 32-37. doi:10.1177/003172171109300308

Nahavandi, A. (2012). *The art and science of leadership* (6th ed.). Upper Saddle River, NJ: Pearson.

Namageyo-Funa, A., Rimando, M., Brace, A. M., Christiana, R. W., Fowles, T. F., Davis, T. L., … Sealy, D. (2014). Recruitment in qualitative public health research:

Lessons learned during dissertation sample recruitment. *Qualitative Report*, *19*(1), 1-17. Retrieved from http://www.nova.edu/ssss/QR/QR19/namageyo-funa1.pdf

National Center for Children Exposed to Domestic Violence. (2006). Domestic violence. Retrieved from http://www.nccev.org/

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979*). The Belmont Report: Ethical principles and guidelines for the protection of human subjects of research* (ERIC Document Reproduction Service No. ED183582). Washington, D.C.: U. S. Government Printing Office.

National Institute of Mental Health. (n.d.). Post-traumatic stress disorder. Retrieved from https://www.nimh.nih.gov/

National Scientific Council Center on the Developing Child at Harvard University. (2007). The science of early childhood development. Retrieved from http://developingchild.harvard.edu/

Newland, L. A. (2014). Supportive family contexts: Promoting child well-being and resilience. *Early Child Development and Care, 184*(9-10), 1336-1346. doi:10.1080/03004430.2013.875543

New York City Department of Health and Mental Hygiene. (2008). Intimate partner violence against women in New York City. Retrieved from http://www.nyc.gov

New York City Domestic Violence Fatality Review Committee. (2014). New York City domestic violence fatality review committee: 2014 report. Retrieved from http://www.nyc.gov/

New York City Mayor's Office to Combat Domestic Violence. (2014). Mayor's office to combat domestic violence: 2014 fact sheet. Retrieved from http://www.nyc.gov/

New York City Mayor's Office to Combat Domestic Violence. (2017). NYC Domestic Violence Task Force: 2017 goals and recommendations. Retrieved from http://www1.nyc.gov/

New York State Child Protective Services Act of 1973, N.Y. U.C.C. § 411-424 (MCKinney, 1976).

New York State Community Action Association. (2014). Seventh annual New York State poverty report. Retrieved from http://nyscommunityaction.org/

New York State Office for the Prevention of Domestic Violence. (n.d.). Intimate partner violence. Retrieved from https://www.oasas.ny.gov/

New York State Office of Children Services. (2014). The Domestic Violence Prevention Act: 2014 report to the governor and legislature. Retrieved from http://ocfs.ny.gov/

New York State Office of Temporary and Disability Assistance. (n.d.a). Shelter oversight and compliance. Retrieved from https://otda.ny.gov/programs/shelter/

New York State Office of the Prevention of Domestic Violence. (n.d.b). Welfare reform and the family violence option. Retrieved from http://www.opdv.ny.gov/

New York State Welfare Reform Act of 1997, N.Y. U.C.C. § 349A (1998).

Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T. L., & Gilbert, L. (2017). Preventing intimate partner violence across the lifespan: A technical

package of programs, policies, and practices. Retrieved from https://www.cdc.gov/

Nouer, S., Mackey, S., Tipton, N., Miller, A., & Connor, P. (2014). Identifying predictors for children witnessing intimate partner violence. *Journal of Family Violence*, *29*(6), 675-679. doi:10.1007/s10896-014-9619-0

Obradovíc, J. (2012). How can the study of physiological reactivity contribute to our understanding of adversity and resilience process in development? *Development and Psychopathology, 24*(2), 371-387. doi:10.1017/S0954579412000053

O'Dell, L., Crafter, S., de Abreu, G., & Cline, T. (2010). Constructing "normal childhoods": young people talk about young carers. *Disability & Society*, *25*(6), 643-655. doi:http://doi.org/10.1080/09687599.2010.505734

O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews, 2015*(7), 1-103. doi:10.1002/14651858.CD007007.pub3

Olaya, B., Ezpeleta, L., de la Osa, N., Granero, R., & Doménech**,** J. M. (2010). Mental health needs of children exposed to intimate partner violence seeking help from mental health services. *Children and Youth Services Review, 32*(7), 1004-1011. doi:10.1016/j.childyouth.2010.03.028

O' Reilly, M. & Parker, N. (2012). Unsatisfactory saturation: A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research, 13*(2), 190-197. doi:10.1177/1468794112446106

Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report, 13*(4), 695-705. Retrieved from http://www.nova.edu/ssss/QR/index.html

Osofsky, J. D. (1999). The impact of violence on children. *The future of Children: Domestic Violence and Children, 9*(3), 38. Retrieved from http://www.futureofchildren.org/

Patton, M. (1990). *Qualitative evaluation and research methods* (pp. 169-186). Beverly Hills, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.) (pp. 3-743). Thousand Oaks, CA: Sage Publications.

Pearl, R. (2013). Domestic violence: The secret killer that costs $8.3 billion annually. Retrieved from https://www.forbes.com/

Pearson, J., Thoennes, N., & Griswold, E. A. (1999). Child support and domestic violence: The victims speak out. *Violence Against Women, 5*(4), 427-448. doi:https://doi.org/10.1177/10778019922181293

Pernebo, K. & Almqvist, K. (2014). Young children's experiences of participating in group treatment for children exposed to intimate partner violence: A qualitative study. *Clinical Child Psychology and Psychiatry, 21*(1), 119-32. doi:10.1177/1359104514558432

Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law No. 104-193, 110 Stat. 2105. (1996).

Pike, A., Coldwell, J., & Dunn, J. F. (2005). Sibling relationships in early/middle childhood: links with individual adjustment. *Journal of Family Psychology*, *19*(4), 523–532. doi:10.1037/0893-3200.19.4.523

PricewaterhouseCoopers Australia. (2015). The economic case for preventing violence against women: A high price to pay. Retrieved from https://www.pwc.com/

Prochaska, J.O., Redding, C.A., & Evers, K. (2002). The Transtheoretical Model and Stages of Change. In K. Glanz, B.K. Rimer & F.M. Lewis, (Eds.) *Health Behavior and Health Education: Theory, Research, and Practice* (3rd Ed.). San Francisco, CA: Jossey-Bass, Inc.

QSR International. (n.d.). NVivo 11 starter full license. Retrieved from http://www.qsrinternational.com/

Randell, K., Bledsoe, L., Shroff, P., & Pierce, M. (2012). Mothers' motivations for intimate partner violence help-seeking. *Journal of Family Violence, 27*(1), 55-62. doi:10.1007/s10896-011-9401-5

Reilly, R. & D'Amico, M. (2011). Mentoring undergraduate university women survivors of childhood abuse and intimate partner violence. *Journal of college student development*, *52*(4), 409-424. doi:https://doi.org/10.1353/csd.2011.0046

Resnick, E. A., & Siegel, M. (2013). *Marketing public health: Strategies to promote social change* (3rd ed.) (pp. 1-29). Burlington, MA: Jones and Bartlett Learning.

Rhodes, K. V., Cerulli, C., Dichter, M. E., Kothari, C. L., & Barg, F. K. (2010). I didn't want to put them through that: The influence of children on victim decision-making in intimate partner violence cases. *Journal of Family Violence, 25*(5), 485-493. doi:10.1007/s10896-010-9310-z

Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D., & Thompson, R. S. (2007). Intimate partner violence and health care costs and utilization for children living in the home. *Pediatrics, 120*(6), 1270-1277. doi:10.1542/peds.2007-1148

Rizo, C. F. & Macy, R. J. (2011). Help seeking and barriers of Hispanic partner violence survivors: A systematic review of the literature. *Aggression and Violence Behavior, 16*(3), 250-264. doi:https://doi.org/10.1016/j.avb.2011.03.004

Robert Wood Johnson Foundation. (2008). Criterion sampling. Retrieved from http://www.qualres.org

Roure, J. G. (2011). Gender justice in Puerto Rico: Domestic violence, legal reform, and the use of international human rights principles. *Human Rights Quarterly, 33*(3), 790-825. doi:10.1353/hrq.2011.0042

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process* (4th ed.) (pp. 27-65). Thousand Oaks, CA: Sage Publications.

Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *The British Journal of Psychiatry, 147*, 598-611. doi:10.1192/bjp.147.6.598

Ryan, C. L. & Siebens, J. (2012). *U.S. Census Bureau, Current Population Reports, P20-566, Educational Attainment in the United States: 2009.* Washington, DC: U.S. Government Printing Office. Retrieved from http://www.census.gov/

Saldaña, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Samsel, M. (2013). Escalation. Retrieved from http://www.abuseandrelationships.org/

Saunders, D. G., Holter, M. C., Pahl, L. C., Tolman, R. M., & Kenna, C. E. (2016). TANF workers' responses to battered women and the impact of brief worker training. *Violence Against Women*, *11*(2), 227-254. doi:10.1177/1077801204271837

Schutz, D., Jaycox, J. H., Hickman, L. J., Setodji, C., Kofner, A., Harris, R., & Barnes, D. (2013). The relationship between protective factors and outcomes for children exposed to violence. *Violence and Victims, 28*(4), 697-714. doi:10.1007/s40653-015-0056-x

Sheehan, B. E., Murphy, S. B., Moynihan, M. M., Dudley-Fennessey, E. & Stapleton, J. G. (2014). Intimate partner homicide new insights for understanding lethality and risks. *Violence Against Women*, *21*(2), 269-288. doi:10.1177/1077801214564687

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63-75. doi:10.3233/EFI-2004-22201

Shin, N. (2013). *Effects of child exposure to domestic violence on the child-parent relationship based on the child's ambivalence toward the parents* (Doctoral

dissertation). Retrieved from ProQuest Dissertations and Theses. (Accession Order No. 3596361).

Smith, E. L. & Farole, Jr., D. J. (2009). Profile of intimate partner violence cases in large urban counties (NCJ 228193). Retrieved from http://bjs.ojp.usdoj.gov/

Social Impact Research. (n.d.). Guide to giving: Empowering victims of domestic violence. Retrieved from http://www.rootcause.org/

Sokoloff, N. J. & Pratt, C. (2006). *Domestic violence at the margins: Readings on race, class, gender, and culture*. New Brunswick, NJ: Rutgers University Press.

Soriano, F. I. (2013). *Conducting needs assessment: A multidisciplinary approach* (2nd ed.) (pp. 121-135). Thousand Oaks, CA: Sage Publications.

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. C. (2012). Barriers to screening for intimate partner violence. *Women Health, 52*(6), 587-605. doi:10.1080/03630242.2012.690840

Stephens, K. (2010). Fostering resilience in children exposed to domestic violence: Practical strategies EC staff can put into action. Marion, IN: Indiana Wesleyan Center for Educational Excellence. Retrieved from ERIC database. (EJ920236).

Sternberg, K. J., Baradaran, L. P., Abbott, C. B., Lamb, M. E., & Guterman, E. (2006). Type of violence, age, and gender differences in the effects of family violence on children's behavior problems: A mega-analysis. *Developmental Review, 26*(1), 89-112. doi:10.1016/j.dr.2005.12.001

Strauss, M. A. (1991, October 30). Children as witness to marital violence: A risk factor for lifelong problems among a nationally representative sample of American men and women. (ERIC Document Reproduction Service No. ED 336713).

Stringer, S. M. (2015). Audit report on the controls of the Department of Homeless Services over the shelter placement and the provision of services to families with children. Retrieved from http://comptroller.nyc.gov/

Suglia, S. F., Duarte, C. S., & Sandel, M. T. (2011). Housing quality, housing instability, and maternal mental health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 88*(6), 1105-1116. doi:10.1007/s11524-011-9587-0

Taft, A., O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L., & Feder, G. (2013). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews,* (4). doi:10.1002/14651858.CD007007.pub2

Tay, I. (2014). To what extent should data saturation be used as a quality criterion in qualitative research? Retrieved from https://www.linkedin.com/

The National Child Traumatic Stress Network. (n.d.). Domestic violence and children. Retrieved from http://www.doj.state.or.us/

Thornton, V. (2014). Understanding the emotional impact of domestic violence on young children. *Educational & Child Psychology, 31*(1), 90-100. Retrieved from http://chicagopolicyreview.org/

Tiet, Q. T., Huizinga, D., & Byrnes, H. F. (2010). Predictors of resilience among inner city youths. *Journal of Child and Family Studies, 19*, 360-378. doi:10.1007/s10826-009-9307-5

Tjaden, P. & Thoennes, N. (2000). Full report of the prevalence, incidence, and consequences of violence against women. Retrieved from https://www.ncjrs.gov/

Toth, S. L., Cicchetti, D., & Kim, J. (2002). Relations among children's perceptions of maternal behavior, attributional styles, and behavioral symptomatology in maltreated children. *Journal of Abnormal Psychology*, *30*(5), 487-501. doi:10.1023/A:1019868914685

Triantafyllou, D., Wang, C., & North, C. S. (2016). Correlates of duration of intimate partner violence among women seeking services at a domestic violence support center. *Journal of Interpersonal Violence, 6*(12), 1-12. doi:10.1177/0886260516647522

Trochim, W. M. K. (2006). *Research methods knowledge base* (2nd ed.). Cincinnati, OH: Atomic Dog Publishing. Retrieved from http://www.socialresearchmethods.net/kb/

Trotter, J. L. & Allen, N. E. (2009). The good, the bad and the ugly: Domestic violence survivors' experiences with their informal social networks. *American Journal of Community Psychology, 43*(3-4), 221-231. doi:10.1007/s10464-009-9232-1

Truman, J. L. & Morgan, R. E. (2014). Nonfatal domestic violence, 2003-2012. Retrieved from http://www.bjs.gov/content/pub/pdf/ndv0312.pdf.

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *Qualitative Report*, *15*(3), 754-760. Retrieved from http://nsuworks.nova.edu/tqr/vol15/iss3/19

Umaña-Taylor, A. J. & Yazedjian, A. (2006). Generational differences and similarities among Puerto Rican and Mexican mothers' experiences with familial ethnic socialization. *Journal of Social and Personal Relationships, 23*(3), 445-464. doi:10.1177/0265407506064214

United Nations. (2010). *The worlds women 2010: Trends and statistics*. New York, NY: Author.

United Nations Children's Emergency Fund. (2006). Behind closed doors: The impact of domestic violence on children. Retrieved from http://www.unicef.org

U. S. Census Bureau. (2010). Hispanic or Latino by type: 2010. Retrieved from http://factfinder.census.gov/

U. S. Department of Health and Human Services. (2014). Injury and violence prevention. Retrieved August 12, 2016, from http://www.healthypeople.gov/2020/

U.S. Preventive Services Task Force. (2013). Screening for intimate partner violence and abuse of elderly and vulnerable adults. Retrieved from http://www.uspreventiveservicestaskforce.org/

University of Pittsburgh Office of Child Development. (2010). Unstable living situations and early childhood mental health. Retrieved from http://www.ocd.pitt.edu/Files/PDF/ECMH-unstableliving.pdf

van Maten, M. (2011). Transcendental phenomenology. Retrieved from http://www.phenomenologyonline.com/

Velleman, R. & Templeton, L. (2007). Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment, 13*(2) 79-89. doi:10.1192/apt.bp.106.002386

Vertinsky, A. T. & Barnes, P. D. (2007). Macrocephaly, increased intracranial pressure, and hydrocephalus in the infant and young child. *Topics in Magnetic Resonance Imaging, 18*(1), 31-51. doi:10.1097/RMR.0b013e3180d0a753

Vilela, M. (2012). Conducting interviews. In University of Kansas (Eds.), *The Community Tool Box: Assessing community needs and resources* (sec. 6). Retrieved from http://ctb.ku.edu/en/tablecontents/sub_section_main_1018.aspx

Vitto, J. M. (2001). Asset building and resiliency. Retrieved from http://cvms.canfield.k12.oh.us/Walby, S. (2004). The cost of domestic violence. Retrieved from http://paladinservice.co.uk/

Walden University. (2016). Red flag issues that should trigger a research ethics consultation with the Institutional Review Board (IRB). Retrieved from http://academicguides.waldenu.edu/

Walker, L. (1979). The Battered Woman. New York: NY: Harper and Row.

Western Australian Centre for Health Promotion Research. (2010). Resilience theory. Retrieved October 2, 2015, from http://mypeer.org.au/

White, M. E. & Satyen, L. (2015). Cross-cultural differences in intimate partner violence and depression: A systematic review. *Aggression and Violent Behavior, 24*, 120–130. doi:10.1016/j.avb.2015.05.005

Wilson, D. & Neville, S. (2009). Culturally safe research with vulnerable populations. *Contemporary Nurse, 33*(1), 6979. doi:10.5172/conu.33.1.69

World Health Organization. (n.d.). Intimate partner violence. Retrieved from http://www.who.int/

World Health Organization. (2001). *WHO multi-country study on women's health and domestic violence progress report*. Geneva, CH: Author.

World Health Organization. (2002). Intimate partner violence. Retrieved from http://www.who.int/

World Health Organization. (2003). Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva, CH: Author. Retrieved from www.who.int/gender/

World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*. Geneva, CH: Author.

World Health Organization. (2012). *Violence prevention alliance global campaign for violence prevention: Plan of action for 2012-2020*. Geneva, CH: Author.

World Health Organization. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva, CH: Author.

World Health Organization. (2014). The cycles of violence. Retrieved from http://www.euro.who.int/

Yates, T. M., Dodds, M. F., Sroufe, L. A., Egeland, B. (2003). Exposure to partner violence and child behavior problems: A prospective study controlling for child

physical abuse and neglect, child cognitive ability, socioeconomic status, and life stress. *Development and Psychopathology, 15*(1), 199-218. doi:10.1017/S0954579403000117

Yoshioka, M. R. & Choi, D. Y. (2005). Culture and interpersonal violence research: Paradigm shift to create a full continuum of domestic violence services. *Journal of Interpersonal Violence, 20*(4), 513-519. doi:10.1177/0886260504267758

Zayas, L. H., & Palleja, J. (1988). Puerto Rican familism: Considerations for family therapy. *Family Relations*, *37*(3), 260-64. doi:10.2307/584559

Zill, N. (2015). Kids of single parents more likely to witness domestic violence. Retrieved from https://ifstudies.org/

Appendix A: Content Validated Semi-Structured Interview Protocol

Interview Protocol: The Effect of Intimate Partner Violence on their Children aged 6-11 years: Perceptions of Low-income Puerto Rican Women Living in New York

Time of Interview:

Date:

Place:

Participant Number:

Dear Participant,

My name is Maria Natal-Gopin, I'm a student at Walden University where I'm pursuing a Ph.D. in Public Health and am also a registered nurse. I'm here because I am learning about mothers who have experiences with IPV and their children.

The purpose of this study is to understand your experiences with the topic of child exposure to intimate partner violence and how your child is doing. You meet the study's participant criteria of being a victim of intimate partner violence and of having a primary school-age Puerto Rican child who has witnessed intimate partner violence. Children questions over the next 90 minutes and I'll also be audio recording the interview and taking short notes during our time together. We will be meeting again for approximately 60 minutes, and I'll contact you so we can arrange the interview within the next couple of weeks. If you chose to participate, your feedback in this study would provide valuable information which will be used to inform culturally appropriate social changes to enhance the well-being and health of children exposed to intimate partner violence. Do you have any questions before we begin? Thanks, let's get started.

Part 1: First tell me a little about you.

1. What is your age?
2. Where were you born?
    1. If born outside of the US, how long have you been in the US?
3. What was the highest grade you completed in school?
4. What is your current annual family income?
5. Are you single, married, divorced, widowed, or living with a partner?
6. How many children do you have?
7. What are the ages of your children?
    1. If there's more than on IPV-exposed child aged six to 11 years each one will be discussed separately.

Part 2: Culture and values

1. What are some of the cultural values that are important to you as a Puerto Rican or Boricua woman? Can you please describe them?
2. Are there any cultural or personal values that you think influence you, your family or your relationships?
3. Based on your living situation, how would you describe your role in your immediate family?

Part 3: Opening question

Trigger: I'm going to be asking you sensitive questions in order to better understand your experiences with violence.

1. Could you talk about instances in where you felt that you were being abused (i.e., stalked, threatened, verbally, financially, physically or sexually) while in front or close proximity of your child, by a partner?

Prompts

1. Please describe how you think your child was exposed to the incident(s)? (A child could be exposed in utero during pregnancy, by intervening, voluntarily or involuntarily participating, being victimized during the incidents, being a direct witness, overhearing it, observing the immediate result, being involved in the aftermath, hearing of it, or thought not to be aware).
2. What are some of the reactions you noticed in your child immediately, during or after the incident?
3. In your opinion, how, if at all, do you think your child is affected by having been exposed to the abuse?
4. What effect does your child's reaction have on your life?
5. In what ways do you think your experience have affected the environment at home for you and your child?
6. How does your child interact with you? Other children? Adults? Siblings?
7. Please describe your experiences and the overall relationship that you have with your child?
8. How does your child perform in school? What are some of his or her average grades?

9. Have you seen any changes in your child's behavior since the abusive incidents? If so, what type of changes?
10. Please describe your experiences with friends, family members, other places, and/or the community in terms of support for you and your child?
11. Who do you think your child would talk to about the abusive incidents?
12. Why do you feel your child would talk to this person?
13. If there were occasions when your child did speak to someone about the incidents he or she was exposed to, can you give me an example of how you think it did or didn't help?
14. How would you describe the coping skills of your child?
15. Are there any items that we haven't yet discussed, that you'd like to bring up?
16. Do you have any questions for me or any recommendations for additional questions about what we've discussed today?

I will be transcribing the information from this interview within the next few days and will contact you so we can arrange our second interview. I will also be providing you with a copy of the interview after I transcribe it and would appreciate your feedback and any suggestions you may have for changes. Lastly, I'll be contacting you to discuss the overall results of the study once I have completed it. Thank you very much for your courage and participation in this project.

Appendix B: Protocolo Validado de Entrevista Semi-estructurada

Protocolo de Entrevista: Efecto de la violencia de pareja intima en sus hijos de 6-11 años: Percepciones de Madres Puertorriqueñas viviendo en Nueva York de bajos ingresos

Hora de la entrevista:

Fecha:

Lugar:

Número de Participante:

Estimado participante:

Mi nombre es María Natal-Gopin, soy una estudiante de la Universidad Walden donde estoy persiguiendo un PhD. en Salud Pública y también soy enfermera registrada. Estoy aquí porque estoy aprendiendo acerca de las madres que tienen experiencias con el IPV y sus hijos.

El propósito de este estudio es entender sus experiencias con el tema de la exposición de los niños a la violencia de pareja y la forma en que esta su hijo. Usted cumple con los criterios de los participantes del estudio de ser víctima de la violencia de pareja y de tener un hijo puertorriqueño de edad escolar primaria que ha sido testigo de la violencia de pareja. Los niños pueden estar expuestos a la violencia de pareja en muchos aspectos. Mi papel en actualidad es hacerle algunas preguntas en los próximos 90 minutos y, con su permiso, yo también estaré grabando la entrevista y tomare notas durante nuestro tiempo juntos. Nos reuniremos de nuevo durante aproximadamente 60 minutos, y yo me comunicare con usted dentro de un par de semanas para organizar la entrevista. Si ha elegido/a participar, su colaboración en este estudio proporcionará

información valiosa que se utilizará para informar a los cambios sociales culturalmente apropiadas para mejorar el bienestar y la salud de los niños expuestos a la violencia de pareja. ¿Tiene algunas preguntas antes de empezar? Gracias. Vamos a comenzar.

Parte numero 1: Primero: dígame un poco sobre usted.

1. ¿Cuál es su edad?
2. ¿Dónde naciste?
    a) si no nació en los Estados Unidos, ¿cuánto tiempo llevas en Estados Unidos?
3. ¿Cuál fue su más alto grado completado en la escuela?
4. ¿Cuál es su ingreso anual de su familia?
5. ¿Eres soltera, casada, divorciada, viuda o vive con una pareja?
6. ¿Cuántos hijos tiene?
7. ¿Cuáles son las edades de sus hijos?
    a. Si hay más de un niño expuesto al IPV de 6 a 11 años, se discutirán cada uno separado.

Parte numero 2: Cultura y valores

1. ¿Cuáles son algunos de los valores culturales que son importantes para usted como mujer puertorriqueña o Boricua? ¿Puede describirlos?
2. ¿hay cualquier cultural o valores personales que usted piensa influyen a usted, su familia o sus relaciones?
3. Basado en su situación de vida, ¿Cómo describirías tu rol en su familia inmediata?

Parte numero 2: Preguntas de apertura

Gatillo: voy a hacerle sensibles preguntas para entender sus experiencias con la violencia.

1. ¿podría hablar sobre las instancias en donde sentías que estaba maltratada (acechada y amenazada, verbalmente, financieramente, físicamente o sexualmente) por su pareja al frente o cerca de su hijo?

Sugerencia

1. ¿Por favor describa cómo usted crees que su hijo/a fue expuesto al incidente (s)? (Un niño podría ser expuesto en útero durante embarazo, interviniendo, participación voluntariamente o involuntariamente, victimizada durante los incidentes, siendo un testigo directo, oír por casualidad, observando el resultado inmediato, estar involucrado después, oyendo de esto, o pensó no ser consciente).
2. ¿Cuáles son algunas de las reacciones que notaste de inmediato, durante o después del incidente en tu niño?
3. En su opinión, ¿cómo, en todo caso, ¿usted piensa que su hijo/a está afectado por haber estado expuestos al abuso?
4. ¿Qué efecto tiene la reacción de su hijo en su vida?
5. ¿de qué maneras crees tú experiencia han afectado el ambiente para usted y su niño en el hogar?
6. ¿cómo interactúa el niño con usted? ¿Otros niños? ¿Adultos? ¿Hermanos?
7. por favor describa sus experiencias y la relación general que tiene con su hijo?
8. ¿Cómo realiza el niño en la escuela? ¿Cuáles son algunos de sus grados promedio?

9. ¿has visto los cambios en el comportamiento de su hijo desde los incidentes de abusivos? Si es así, ¿qué tipo de cambios?
10. ¿Por favor describa sus experiencias con amigos, miembros de su familia, otros sitios y/o la comunidad en términos de apoyo a usted y su hijo?
11. ¿A quién cree que su hijo se dirigiría hablar sobre los incidentes abusivos?
12. ¿Por qué siente que su hijo se dirigiría hablar con esta persona?
13. ¿Si hubo ocasiones cuando su hijo hizo hablar con alguien acerca de los incidentes que él o ella estaba expuesta, me puede dar un ejemplo de cómo usted piensa que hizo o no ayuda?
14. ¿Cómo describiría las habilidades de adaptación de su hijo?
15. ¿Hay elementos que aún no hemos discutido, que le gustaría traer?
16. ¿Tiene alguna pregunta para mí o cualquier recomendación para preguntas adicionales acerca de lo que hemos hablado hoy?

Voy a transcribir los datos de esta entrevista en los próximos días y luego me comunicare con usted para que podamos organizar nuestra segunda entrevista. También le proporcionaré una copia de la entrevista después de que lo transcribo y agradecería sus comentarios y cualquier sugerencia que puedas tener sobre los cambios. Finalmente, me comunicare con usted para hablar de los resultados totales del estudio una vez que lo haya completado. Muchas gracias por su valor y la participación en este proyecto.

Appendix F: Research Assistant Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Name of Signer: Research Assistant

During the course of my activity in collecting data for this research: Mothers' Perceptions of the Effects of Intimate Partner Violence on their Primary School-age Puerto Rican Children". I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**

Appendix G: Observation Protocol

Length of Activity: 60-90 minutes	
Descriptive Notes	Reflective Notes

Appendix H: Study Participant Screener

Recruitment Goals:

- The participants will be Puerto Rican mothers over 18 years of age
- The participants will self-identify as a victim of intimate partner violence
- The participants will have an IPV-exposed child aged 6-11
- The participants will agree to participate in two audio-taped interviews

Schedule:

Mondays: 9 am to 5 pm

Tuesdays: 9 am to 2 pm

Wednesdays: 9 am to 5 pm

Thursdays: 9 am to 5 pm

Friday: 9 am to 2 pm

Weekends and evenings will be scheduled based on the participant's preferences

Token of appreciation:

Each of the participants will be provided with a $10.00 Target gift card at the beginning of the first interview and a $10.00 Target gift card at the beginning of the second interview as a token of appreciation regardless of whether they decide to participate in the entire interviews or not, or stop once the interview has started.

Other:

The privacy and confidentiality of the screened and excluded participants will be assured. Excluded participant data will be aggregated and reported. Attrition rates will be tracked and reported.

English Prospective Participant Screening Questions:

Hello, my name is Maria Natal-Gopin, thanks for contacting me about the Puerto Rican child resilience research study. I will need about 15 minutes of your time to confirm that you are eligible to participate in the study. May we proceed?

1. What is your date of birth? _____
   If birth year is 1971 and above-proceed
   If birth year is <1971---**terminate ineligible**
2. Are you of Hispanic, Latino or Spanish origin?
   No, not of Hispanic, Latino or Spanish---**terminate ineligible**
   Yes, Puerto Rican-proceed
   Yes, Mexican American, Mexican or Chicano----**terminate ineligible**
   Yes, Cuban----**terminate ineligible**
   Yes, other Hispanic, Latino, or Spanish origin –Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on below: _____----**terminate ineligible**
3. Do you live in New York City?
   - No**---terminate ineligible**
   - Yes-proceed
4. Are you the biological, custodial or adopted mother to a child?
   - No ---**terminate ineligible**
   - Yes-proceed
5. How many children do you have and what are their ages?
   Add #_____ Add ages_____
   - Non school-age (6-11) ---**terminate ineligible**
   - Primary school-age-proceed
6. Have you been in a relationship with an intimate partner where you were afraid, stalked, hit, hurt, threatened, sexually, financially, or verbally abused?
   - No ---**terminate ineligible**
   - Yes-proceed
7. Has your school-age son or daughter ever been exposed to any incidents of violence?
   - No**---terminate ineligible**
   - Yes-proceed
8. At this time, are you or your children at risk of domestic disturbances from your current or former intimate partner?
   - No-proceed
   - Yes---**terminate ineligible** (Thank and provide resources)

9. Would you be willing to share your experiences about how exposure to domestic disturbances, between you and your partner, may have impacted your child?
   - Yes-proceed
   - No---**terminate ineligible**
10. Would you be willing to participate in two prearranged audiotaped interviews in a private office in the community with a female researcher?
   - Yes-proceed
   - No---**terminate ineligible**

Ineligible Closing:

At the first "terminate ineligible" question I will say: Thank you for contacting me and for taking the time to answer the screening questions. I have specific criteria for the study participants, and based on the response you provided, I will not be able to interview you for the study. I want to thank you for your courage and willingness to have participated.

Eligible Closing:

Thank you for your time, courage and desire to participate in the Puerto Rican child resilience study. Your answers meet the defined criteria for participating in the study. I'd like to take a few minutes to provide you with a short introduction and then I will answer any questions you may have. You are invited to participate in two audiotaped face-to-face interviews which will take place in a private office at the East Side House Settlement or the Mott Haven public library in the South Bronx area with me. The first interview will take about 1 ½ hours and you will receive a $10.00 Target gift card, at the beginning of the interview, as a token of appreciation for your time. The second interview will last about one hour and you will receive a second $10.00 Target gift card, at the beginning of the interview, as a token of appreciation for your time. Please note that children will not be allowed during the first or second interview and that you will need to make childcare

arrangements. If you are unable to attend the interview, please contact me as soon as possible so we can reschedule it.

Do you have any questions about the study or anything I have discussed so far?
- Yes_____
- No

Would you like to participate?
- Yes-proceed
- No---**terminate and thank for their time**

Let's go ahead and schedule the first interview, what day and time work best for you?
Date: _____ Time: _____

Spanish Prospective Participant Screening Questions:

Hola, me llamo Maria Natal-Gopin, gracias por contactarme sobre el estudio puertorriqueño de resiliencia de niño puertorriqueño. Necesitaré alrededor de 15 minutos de su tiempo para confirmar que usted es elegible para participar en el estudio. ¿Podemos proceder?

Objetivos de reclutamiento:

- Las participantes serán madres puertorriqueñas de más de 18 anos
- Las participantes se identificarán como víctimas de violencia de pareja intima
- Las participantes tendrán hijos que han experimentado viendo sus madres ser víctimas de violencia de pareja intima
- Las participantes están de acuerdo de participar en 2 entrevistas recordadas por grabación de audio

Horario:

Lunes: 9am a 5pm

Martes: 9am a 2pm

Miercoles: 9am a 5pm

Jueves: 9am a 5pm

Viernes: 9am a 2pm

Fines de semana y más tarde del horario, estarían dispuestos a las preferencias de las participantes.

Muestra de agradecimiento:

Como un regalo de agradecimiento por su valor y su tiempo para participar en este estudio, se le proporcionará una tarjeta de regalo de $10.00 a Target al principio de la primera entrevista y una tarjeta de regalo de $10.00 a Target al comienzo de la segunda entrevista.

Otro:

La privacidad y confidencialidad de las participantes serán aseguradas. Los datos de participantes excluidos serán agregados e informados. Las tasas de deserción serán rastreadas e informadas.

Preguntas de Evaluación de Participantes Prospectivas en español:

Hola, mi nombre es Maria Natal-Gopin, gracias por contactarme sobre el estudio puertorriqueño de resiliencia de niño puertorriqueño. Necesitaré alrededor de 15 minutos de su tiempo para confirmar que usted es elegible para participar en el estudio. ¿Podemos proceder?

1. ¿Cuál es su fecha de nacimiento? _____
   Si el año de nacimiento es 1971 o superior, proceda
   Si el año de nacimiento es <1971 --- **finalizar inelegible**
2. ¿Es de origen hispano, latino o español?
   No, no de hispanos, latinos o españoles --- **finalizar inelegible**

Sí, puertorriqueño-proceda
Sí, mexicana americana, mexicana or chicana --- **finalizar inelegible**
Si, cubana --- **finalizar inelegible**
Si, otro origen hispano, latino o español - escribir origen abajo:
_____---- **finalizar inelegible**

3. ¿Vives en la ciudad de Nueva York?
   No --- **finalizar inelegible**
   Sí, continúa
4. ¿Es usted la madre biológica, de custodia o adoptiva de cualquier niño puertorriqueño?
   □ No --- **finalizar inelegible**
   □ Sí, continúa
5. ¿Cuántos niños tiene y cuáles son sus edades?
   Añadir #_____ Añadir edades_____
   □No entre las edades de 6 y 11 años--- **finalizar inelegible**
   □ Si entre las edades de 6 y 11 años -proceder
6. ¿Ha estado en una relación con una pareja íntima donde tuvo miedo, acechado, golpeado, herida, amenazada, sexual, financiero o verbalmente maltratada?
   □ No --- **finalizar ineligible**
   □ Sí, continúa
7. ¿Han estado sus hijos entre las edades de 6 y 11 años expuestos a cualquier incidente de violencia?
   □ No --- **finalizar ineligible**
   □ Sí, continúa
8. ¿En este momento, usted o sus hijos corren el riesgo de sufrir trastornos domésticos de parte de su pareja actual o ex pareja íntima?
   □ No-continúa
   □ Sí --- **finalizar inelegible** (Agradecer y proporcionar recursos)
9. ¿Estaría dispuesta a compartir sus experiencias acerca de cómo la exposición a los disturbios domésticos, entre usted y su pareja, puede haber impactado a su hijo puertorriqueño en edad escolar?
   □ Sí- continúa
   □ No --- **finalizar inelegible**
10. ¿Estaría dispuesta a participar en dos entrevistas arreglado grabadas en una oficina privada en la comunidad con una investigadora?
    □ Sí- continúa
    □ No --- **finalizar ineligible**

Cierre Inelegible:

En la primera pregunta de "finalizar inelegible" diré: Gracias por contactarme y por tomarse el tiempo para responder a las preguntas de la selección. En este momento, tenemos una categoría específica para los participantes del estudio y, basándonos en la

respuesta que nos proporcionó, no podremos entrevistarle para el estudio. Quiero agradecerles su valor y su voluntad de haber participado.

Cierre Elegible:

Gracias por su tiempo, valor y deseo de participar en el estudio puertorriqueño de resiliencia de niños. Sus respuestas cumplen con las categorías definidas para participar en el estudio. Me gustaría tomar unos minutos para ofrecerle una breve introducción y luego responderé cualquier pregunta que pueda tener. Usted está invitada a participar en dos entrevistas cara a cara grabadas en audio que tendrán lugar en una oficina privada en el East Side House Settlement o en la biblioteca pública de Mott Haven en el área del sur del Bronx conmigo. La primera entrevista tomará aproximadamente 1½ hora y usted recibirá una tarjeta de regalo de $10.00 Target, al principio de la entrevista, como una muestra de agradecimiento por su tiempo. La segunda entrevista durará aproximadamente una hora y usted recibirá una tarjeta de regalo de $10.00 Target, al principio de la entrevista, como una muestra de agradecimiento por su tiempo. Tenga en cuenta que los niños no serán permitidos durante la primera o segunda entrevista y que usted necesitará hacer arreglos de cuidado de niños.

¿Tiene alguna pregunta sobre el estudio o algo que he discutido hasta ahora?
□ Sí_____
□ No

¿Le gustaría participar?
□ Sí- continúa
□ No --- **terminar y agradecer por su tiempo**

Vamos a seguir adelante y programar la primera entrevista, ¿qué día y hora funcionan mejor para usted? Fecha y hora: _____

Appendix I: Research Flyer

Puerto Rican Family Relations *Research Study*

This research study is for adult Puerto Rican mothers who have children aged six-11 years who have been exposed to intimate partner violence. The researcher wants to learn more about the experiences of Puerto Rican mothers of how intimate partner violence may have impacted their child. The study involves two separate interviews in a prearranged private location in the South Bronx community.

How do I know if I'm eligible to participate?

- You are a Puerto Rican mother over 18 years of age and speak Spanish or English
- You have experiences with intimate partner disturbances
- You have a child aged six-11 years who was exposed to intimate partner disturbances

What would I need to do if I participated?

- You would meet with a female researcher for two planned face-to-face interviews in a private office. The first interview will last 1 ½ hours and the second interview will last about 1 hour
- You agree to have the researcher contact you to arrange the second interview and would provide some feedback on the study once the data has been interpreted
- The researcher would disguise your identity by using a code to protect your privacy
- You would not be able to bring your children to the interviews
- You agree to have the two interviews audiotaped
- You agree to provide informed consent

This study may not have a direct benefit to you but your participation in this study may help other mothers and their children. Some of the questions may impact you emotionally but you will be provided with a list of free bilingual support resources in your community.

For taking part in this study, you will be provided with a $10.00 Target gift card at the beginning of the first interview and a $10.00 Target gift card at the beginning of the second interview as a thank you gift for your time.

If you want to participate or have any questions, please call Maria Natal-Gopin at (973) 943-8621 or email maria.natal-gopin@waldenu.edu

Appendix J: Folleto de investigación

Estudio de Investigación de Relaciones de La Familias Puertorriqueñas

Este estudio de investigación es para madres puertorriqueñas adultas que tienen niños entre 6 y 11 años de edad que han estado expuestos a violencia de pareja íntima. La investigadora de quiere aprender sobre las experiencias de las madres puertorriqueñas acerca de cómo los trastornos de las parejas íntimas pueden haber impactado a su hijo o hija. El estudio supone dos entrevistas separadas en un lugar privado preestablecido en la comunidad del sur del Bronx.

¿Cómo sé si soy elegible para participar?

- Usted es una madre puertorriqueña de 18 años o más y habla español o inglés
- Tienes experiencias con trastornos de pareja íntima
- Usted tiene un niño de edad seis a11 años que estuvo expuesto a disturbios de pareja íntima

¿Qué necesito hacer si participé?

- Usted se reuniría con una investigadora para dos entrevistas cara a cara en una oficina privada. La primera entrevista durará no más de 1½ hora y la segunda entrevista durará aproximadamente 1 hora
- Usted acepta que la investigadora se pondrá en contacto con usted para organizar la segunda entrevista y le proporcionará algún comentario sobre el estudio una vez que se hayan interpretado los datos
- La investigadora disfrazaría su identidad usando un código para proteger su privacidad
- Usted no podría traer a sus niños a las entrevistas
- Usted acepta que las dos entrevistas sean grabadas en audio
- Usted dará su consentimiento

Este estudio no tendrá un beneficio directo para usted, pero su participación en este estudio podrá ayudar otras madres y sus hijos. Algunas de las preguntas pueden afectarle emocionalmente, pero se le proporcionará una lista de recursos bilingües gratuitos en su comunidad que le pueden dar apoyo gratis.

Como un regalo de agradecimiento por su valor y su tiempo para participar en este estudio, se le proporcionará una tarjeta de regalo de $10.00 a Target al principio de la primera entrevista y una tarjeta de regalo de $10.00 a Target al principio de la segunda entrevista como un regalo de agradecimiento por su tiempo.

Si desea participar o si tienes algunas preguntas, llame a Maria Natal-Gopin al (973) 943-8621 o envíe un correo electrónico a maria.natal-gopin@waldenu.edu

Appendix K: Expert Panel Review Protocol

Dear _____,

My name is Maria Natal-Gopin, and I am a Public Health Ph.D. student at Walden University where I am working on my dissertation titled *The Effect of Intimate Partner Violence on their Children aged 6-11 years: Perceptions of Low-income Puerto Rican Women Living in New York*. The study focuses on the risks and protective factors of children who have been exposed to intimate partner violence as perceived by their Puerto Rican mothers. I have created a semi-structured interview protocol and am writing to you in the hope that you would be willing to serve on my panel of experts by reviewing the protocol. You have been chosen because of your professional expertise in the field of intimate partner violence.

Intimate partner violence has reached epidemic proportions and the effects on children who are exposed to it have only recently come to the forefront. Among some children, exposure can result in short and long term physical, psychological, social, and environmental issues. Culture plays a key role in the developmental adaptive capacity of children and exploring this issue from the understudied second largest Hispanic sub-group is vital to empowering Puerto Rican mothers to disclose IPV and to better inform health care providers regarding the impact of IPV on their children aged six-11 years in an effort to increase the health, well-being and resiliency of this vulnerable population.

The purpose of this study is to explore and understand the lived experiences of Puerto Rican mothers who are victims of intimate partner violence and their perceptions

of how exposure to intimate partner violence may have impacted their children. This study is in alignment with the need to explore how the unique subcultural values and beliefs influence Hispanic sub-groups using a cultural mindset.

As a member of my panel of experts, you would review and provide me with feedback on the semi-structured interview protocol I've developed for this study. The initial private one-on-one participant interview will last 90 minutes and the follow-up interview will last 60 minutes. Part one of the protocol consists of five demographic questions, part two consists of one opening question and 17 prompts.

As a token of appreciation for your time and effort, I will provide you with a $25.00 Visa gift card or a donation to a charity of your choice. It would be greatly appreciated if you would please contact me at (973) 943-8621 if you're willing to be a member of my expert panel by _enter date__.

I look forward to hearing from you and have attached the expert panel review tool with the interview questions for your convenience on the following three pages. In advance, I would like to thank you for your consideration in being a member of my expert panel.

Sincerely,

Maria Natal-Gopin

Expert Panel Review Tool

	Tone		Wording		Topic Alignment		Suggestions/ Changes
Part 1: What is your current age?	Yes	No	Yes	No	Yes	No	
How many children do you have?	Yes	No	Yes	No	Yes	No	
What was your highest grade completed in school?	Yes	No	Yes	No	Yes	No	
What is your current annual family income?	Yes	No	Yes	No	Yes	No	
What is your marital status?	Yes	No	Yes	No	Yes	No	
Part 2: Could you talk about some of your experiences with being stalked, hit, threatened, sexually, financially, or verbally abused in front of your child by a former or current partner?	Yes	No	Yes	No	Yes	No	
Prompts: How did your child react?	Yes	No	Yes	No	Yes	No	
What lived effect did this have on your life?	Yes	No	Yes	No	Yes	No	
What was it like at home for you and your children?	Yes	No	Yes	No	Yes	No	

Tell me about some of the cultural values that are important to you as a Puerto Rican?	Yes	No	Yes	No	Yes	No	
Describe how the values have influenced you, your family or your relationships?	Yes	No	Yes	No	Yes	No	
How would you describe your role in the family?	Yes	No	Yes	No	Yes	No	
How do you think your child has been affected by the situations he or she was exposed to?	Yes	No	Yes	No	Yes	No	
Tell me about your child's interactions with you, other kids and adults?	Yes	No	Yes	No	Yes	No	
Please describe your experiences of the relationship you have with your child?	Yes	No	Yes	No	Yes	No	
What are some of the grades your child gets in school?	Yes	No	Yes	No	Yes	No	
What, if any, behavioral changes have you seen in your child since he	Yes	No	Yes	No	Yes	No	

witnessed the incidents?							
How would you describe your experiences with support from friends, the community or family members that you and your child have received as victims of intimate partner violence?	Yes	No	Yes	No	Yes	No	
If your child wanted to talk about the incident with someone who would he/ she tell?	Yes	No	Yes	No	Yes	No	
Why do you feel he/she trust them?	Yes	No	Yes	No	Yes	No	
Can you give me an example of how you think it did or didn't help?	Yes	No	Yes	No	Yes	No	
Tell me, what else would you like to talk about that we haven't discussed?	Yes	No	Yes	No	Yes	No	
What suggestions do you have for additional questions on this topic?	Yes	No	Yes	No	Yes	No	